

# **Universidade Nova de Lisboa, Faculdade de Ciências Médicas**



## **Master's Dissertation in International Mental Health**

### **Analysis of mental health service financial models with a particular emphasis on Ireland**

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**Year of completion of the dissertation: 2012**

## **Abstract**

Financing is a critical factor in ensuring the optimal development and delivery of a mental health system. The primary method of financing worldwide is tax-based. However many low income countries depend on out-of-pocket payments. There is a report on Irish Health Care funding but none that deals exclusively with mental health care.

This paper analyses the various financial models that exist globally with respect to financing the mental health sector, examines the impact of various models on service users, especially in terms of relative 'financial burden' and provides a more detailed examination of the current mental health funding situation in Ireland

After extensive internet and hardcopy research on the above topics, the findings were analysed and a number of recommendations were reached.

Mental health service should be free at the point of delivery to achieve universal coverage. Government tax-based funding or mandatory social insurance with government top-ups, as required, appears the optimal option, although there is no one funding system applicable everywhere.

Out-of-pocket funding can create a crippling financial burden for service users. It is important to employ improved revenue collection systems, eliminate waste, provide equitable resource distribution, ring fence mental health funding and cap the number of visits, where necessary.

Political, economic, social and cultural factors play a role in funding decisions and this can be clearly seen in the context of the current economic recession in Ireland. Only 33% of the Irish population has access to free public health care and the number health insurance policy holders has dramatically declined, resulting in increased out-of-pocket payments. This approach risks negatively impacting on the social determinants of health, increasing health inequalities and negatively affecting economic productivity.

It is therefore important the Irish government examines other options to provide funding for mental health services.

Key words: Financial models, mental health funding, Ireland, health inequalities, social determinants, health insurance.

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## 1. Introduction

The objectives of this thesis are to

1. Provide an overview of the various financial models that exist globally with respect to financing the mental health sector, taking into account high-resource, middle-resource and low-resource countries.
2. Examine implications of the various models in terms of their impact on mental health service users, paying special attention to issues such as the relative financial burden they impose and equality of access to services and treatment.
3. Undertake a more detailed examination of the current mental health funding situation in Ireland including an analysis of the requirements of Irish mental health service users, the demand for mental health services, the social determinants that lead to varying needs amongst mental health service users as well as the history and current funding system.
4. The thesis concludes with a brief summary of certain of the paper's main points and recommendations on mental health system financing.

The financing of a national mental health system is of critical importance in ensuring the optimal development and delivery of the services, treatment and prevention programmes required to cater for a country's mental health. It is the mechanism by which mental health plans and policies are translated into action through the effective and efficient allocation of resources.<sup>1</sup>

In 2001, the WHO collected information on available mental health care resources in 89 countries worldwide as part of the Atlas Project. This project revealed that the primary method of financing was tax-based (60.2%) although many low income countries were also dependent on out of pocket expenditures. Furthermore, it found that in addition to there being a great disparity between the burden of mental health problems and resources allocated, the presence of a mental health policy and plan did not necessarily mean a realistic proportion of the health budget was allocated to mental health.<sup>2</sup>

This thesis therefore starts by examining some of the many different mental health system financial models in order to better understand the options and modalities available to those responsible for managing the funding of mental health systems. In addition, the paper will examine the political-economic and socio-economic mechanisms that lie behind the choice of mental health financing paradigms, the cost effectiveness of various models in delivering mental health care and how care receivers are affected by the cost of their treatment or services they need to access. The impact of different funding mechanisms on various categories of mental health service users is also assessed. These factors, though frequently neglected, are critical in estimating the real social and economic costs of mental health and provide a crucial argument as to the importance of adequate mental health funding.

To complement the general findings of how mental health financing works and the impact it has on service users, the paper takes a more in-depth look at the mental health financing situation in Ireland and how it has evolved. Ireland is a particularly interesting case given the severe strain placed on the Irish health system in general and the mental health system in particular due to the current economic recession which has resulted in serious health expenditure cutbacks over the past few years.

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<sup>1</sup> WHO (2003) *Mental Health Financing: Mental Health Policy and Service Guidance Package*. WHO: Geneva. [http://www.who.int/mental\\_health/policy/services/essentialpackage1v4/en/index.html](http://www.who.int/mental_health/policy/services/essentialpackage1v4/en/index.html). p. 2

<sup>2</sup> Commission on Financial Management and Control Systems in the Health Service (2003) *Report of the Commission on Financial Management and Control Systems in the Health Service*. Government Publications Office: Dublin. <http://www.finance.gov.ie/documents/publications/other/brennan.pdf>

This analysis is undertaken by taking into account the levels of mental health service needs in Ireland, public attitudes towards mental health and the influence of social determinants in creating health inequalities and thence varying needs amongst different social strata.

Although a general report on the financial management of the Irish Health system has been produced, there is no one financial report that deals exclusively with the mental health system.<sup>3</sup> Furthermore, while a number of financial methods have been reviewed for various services such as the Chains of Care in Sweden, Care Trusts in England and the veterans' health care system, administered by the U.S. Department of Veterans Affairs (VA), these do not deal with mental health services exclusively.<sup>4</sup>

Moreover, the Irish mental health system has been weakened by the absence of a separate individual with exclusive responsibility within the Irish health system to promote as well as defend mental health funding.<sup>5</sup>

The methodology for this thesis has primarily consisted of desk and internet research, which was then analysed in terms of relevance to the financing of mental health systems. Given both the lack of studies specifically focusing on mental health financing and the overlapping of health and mental health financing, extensive reference was also made to papers and studies focusing on health financing in addition to just mental health funding. Based on this research and the Irish case study, certain conclusions and recommendations have been developed and are presented in the paper's concluding chapter.

Finally, it should be noted that this thesis has been constantly informed by the recommendations made by relevant organisations and scholars, most particularly those of the WHO, with respect to the financing of mental health care.

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<sup>3</sup> Saxena S, Sharan P & Saraceno B (2003) 'Budget and Financing of Mental Health Services: Baseline Information on 89 Countries from WHO's Project Atlas'. *J Ment Health Policy Econ.* 6:135-143.

<sup>4</sup> Weatherly H, Mason A, Goodard M & Wright K (2010) *Financial Integration Across Health and Social Care: Evidence Review*. Scottish Government Social Research: Edinburgh.  
<http://www.scotland.gov.uk/Resource/Doc/303234/0095107.pdf>

<sup>5</sup> Mental Health Reform (2012) *Mental Health in Ireland*. <http://www.mentalhealthreform.ie/home/mental-health-in-ireland/>

## 2. Mental Health Financing and Funding models.

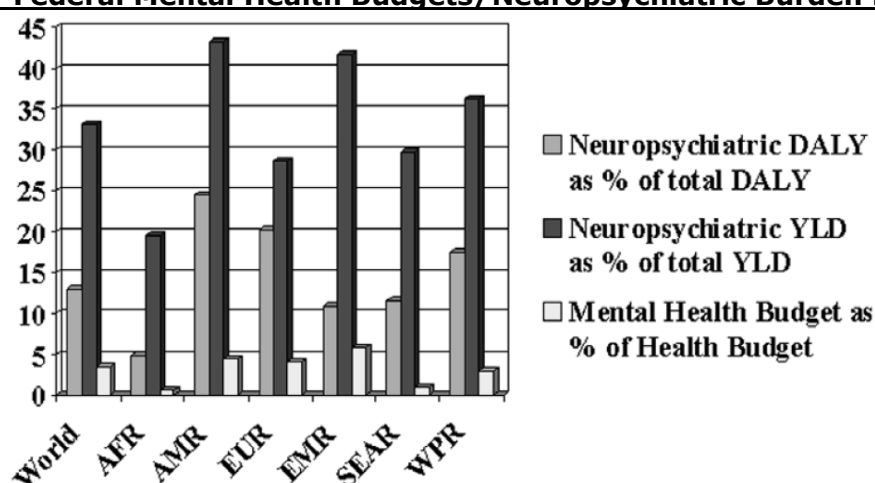
This chapter will look at mental health financing and funding models by firstly examining comparative spending on mental health and the various mental health funding models applied globally. Certain of the more important criteria which are essential in ensuring a successful mental health model and system will then be noted. In conclusion, a number of short mental health case studies will be outlined to highlight some of the major components of mental health funding systems in operation globally.

### 2.1 Comparative spending on mental health

According to a 2007 study published in *Lancet*, African, Eastern Mediterranean, and South East Asian countries spent significantly less of their GDP on health than American, European, and Western Pacific countries. Similarly low-income countries dispense significantly less of their GDP on health than middle-income countries, which in turn spent considerably less of their GDP on health than high-income countries. Only 31% of countries reported not having a specified budget for mental health care.<sup>6</sup>

High-income countries expended more of their health budget on mental health than upper middle-income countries (median 3%), which in turn spent more of their health budget on mental health than low-income countries (1%) and lower middle-income countries (2.1%). European countries (6.3%) spent more of their health budget on mental health than countries in other WHO regions (2.9% and 0.76% respectively).<sup>7</sup> Table 1 below depicts federal mental health budgets by WHO region as well as the burden of Neuro-psychiatric disorders.<sup>8</sup>

**Table 1: Federal Mental Health Budgets/Neuropsychiatric Burden by Region**



In 1984, health spending in the 18 OECD countries (where data were consistently available for all 6 different years) was on average 7.5% of GDP. The US had the highest GDP share (10.7%) and Greece the lowest (4.6%). The average elasticity of 16 of the 18 countries as a group substantially exceeded 1.0 for the 1960-84 period, as well as the 1960-75 (1.6) and 1975-84 (1.3) sub periods. Thus, real health spending increased 60% faster than real GDP between 1960-84 and 1960-75, and 30% faster between 1975-84.<sup>9</sup>

<sup>6</sup> Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, Sreenivas V & Saxena S (2007) 'Mental health systems in countries: where are we now?' *Lancet*. 370(9592):1061-1077

<sup>7</sup> Jacob K S et al (2007) *Ibid*

<sup>8</sup> Saxena S, Sharan P & Saraceno B (2003) 'Budget and financing of mental health services: baseline information on 89 countries from WHO's project atlas.' *J Ment Health Policy Econ*. 6(3):135-43.

<sup>9</sup> Schieber G J & Puollier J P (1986) 'International health care spending.' *Health Aff (Millwood)*. 5(3):111-22



More recently, health spending in OECD countries rose almost 5% per year in real terms between 2000 and 2009. However, this growth ceased in 2010 where there was zero growth. 2011 Preliminary figures indicated there would be minimum if any growth. The zero growth in total health spending was primarily caused by a 0.5% decline in total health spending in 2010, following a rise of over 5% in both 2008 and 2009.<sup>10</sup>

As noted above, the level of financing tends to be far inferior in 'developing' countries. In India, for instance, public spending on health amounts to under 1% of total GDP. This extremely low level of public health expenditure health has resulted in one of the highest proportions of private out-of-pocket expenses globally. Citizens receive low value for money in both public and the private sectors. Financial protection against medical expenditures is far from universal with only 10% of the population having medical insurance.<sup>11</sup>

## **2.2 Health funding models**

The health journalist T.R. Reid divides the world's health funding models into four basic categories:

- a) a government service, similar to a state police force or public library system, paid for through tax revenue
- b) a government-run national insurance scheme paid into by employers and workers via a payroll tax
- c) mandated or voluntary private insurance and
- d) out-of-pocket-only payments<sup>12</sup>

At the global level in 1990 worldwide expenditure on health was about 60% public and 40% private in origin.<sup>13</sup> In 2009, OECD statistics showed public spending still comprised the majority of health spending in all but three member countries namely, the U.S. Mexico and Chile.<sup>14</sup> World Bank statistics on health spending from 2007 to 2010 confirmed that the majority of health spending at the national level emanated from public sources, although a large number of low-resource countries went against this trend.<sup>15</sup>

In a 2003 study, Saxena *et al* found the most common method of financing mental health care was tax-based (60.2%), followed by social insurance (18.7%), out-of-pocket payments (16.4%), external grants (2.9%) and private insurance (1.9%). Out-of-pocket payment, the least equitable method, was used as the primary method of financing health care in 35.9% and 30% of countries in the African and South-East Asia regions respectively. No European country used this method as the primary method of financing mental health care.<sup>16</sup>

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<sup>10</sup> OECD (2012) *Health: Growth in health spending grinds to a halt*. OECD Newsroom. 28/6/2012.

<http://www.oecd.org/newsroom/healthgrowthinhealthspendinggrindstoahalt.htm>

<sup>11</sup> Kumar A K, Chen L C, Choudhury M, Ganju S, Mahajan V, Sinha A & Sen A (2011) Financing health care for all: challenges and opportunities. *Lancet*. 377(9766):668-79

<sup>12</sup> Johnson T. (2009) *Lessons in Universal Health Insurance Models*. Council on Foreign Relations

<http://www.cfr.org/global-health/lessons-universal-health-insurance-models/p19871>

<sup>13</sup> Murray C J, Govindaraj R & Musgrove P (1994) 'National health expenditures: a global analysis.' *Bull World Health Organ.*; 72(4):623-37

<sup>14</sup> OECD (2011) *Health at a Glance 2011: OECD Indicators*. OECD: Paris.

<http://www.oecd.org/els/healthpoliciesanddata/49084488.pdf>

<sup>15</sup> World Bank (2012) *Health Expenditure, Public (% of total health expenditure)*.

<http://data.worldbank.org/indicator/SH.XPD.PUBL>

<sup>16</sup> Saxena S, Sharan P & Saraceno B (2003) *Ibid*

Using 2009 figures, the OEC reports the proportion of health care expenditure covered by households via out-of-pocket payments at approximately 19%. At the national level, out-of-pocket expenses ranged from a high of over 30% in Korea, Mexico and Chile to a low of 6% and 7% in the Netherlands and France respectively. The OECD did add that the practice of informal payments in certain central and east European countries may have led to an underestimation of the share of out-of-pockets expenses in the total health spending figure.<sup>17</sup>

Social insurance was the primary method of financing mental health care in 50% of European countries, while not one of the countries in the African, South-East Asia and Western Pacific regions used social insurance as the primary method of financing mental health care.<sup>18</sup> Tables 2 and 3 below outline the WHO summary of various health care financing methodologies and the major sources of health funding respectively.

**Table 2: WHO Summary of Health Care Financing Methodologies<sup>19</sup>**

- Taxes are the primary method of mental health financing for 60.2% of countries worldwide, followed by social insurance (18.7%) and out-of-pocket payments (16.4%). This percentage varies when examined by WHO regions, but taxes remain the dominant mode of mental health financing in all regions. Private insurance and external grants account for 1.8% and 2.9% respectively.
- Out-of-pocket payment is the second most common method of financing mental health care in 35.9% of countries in the African Region, 30% of those in the South-East Asia Region, 22.2% in the Eastern Mediterranean, 13.3% in the Americas and 11.5% in the Western Pacific Region. No countries in the European Region use this method as the secondary means of expenditure on mental health care.
- Social insurance is the second most common method of financing in 50% of countries in the European Region and only 7.7% of countries in the Western Pacific Region use it as the third most common method of financing mental health care. No countries in the African Region nor the South-East Asia Region use insurance as the second or third most common method of mental health financing.
- Private insurance is used as a method of financing in very few countries world wide (in Africa and the Americas).
- External grants support mental health care in 7.7% of countries in the Western Pacific Region, in 5.6% of countries in the Eastern Mediterranean Region and in 5.1% of countries in the African Region.
- If countries are examined according to income groups (low, lower middle, higher middle and High), tax is the most common primary method of financing.
- Out-of-pocket payment is the second most common method of financing in 39.6% of low-income countries but in none of the higher middle income countries and only 2.9% in high income countries.
- Social insurance is the second most common method of financing in 38.3% of high income countries and in 29.4% of higher middle-income countries. No low-income country uses social insurance as a primary method of financing mental health.

<sup>17</sup> OECD (2012) *Health at a Glance 2011: OECD Indicators*. OECD: Paris. [http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance\\_19991312](http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312)

<sup>18</sup> Saxena S, Sharan P & Saraceno B (2003) *Ibid*

<sup>19</sup> World Health Organization (2010) *The world health report: health systems financing: the path to universal coverage*. World Health Organization: Geneva, Switzerland.

**Table 3: Sources of Mental Health Funding**

<b>Countries</b>	<b>Specific Budget – Mental Health</b>	<b>Mental Health Budget as proportion of General Health Budget</b>	<b>Sources of Mental Health Finance in Descending Order</b>
<b>Australia</b>	Yes	6.5%	Tax-based, private insurance and out-of-pocket
<b>Chili</b>	Yes	4.1%	Social insurance, tax based, out-of-pocket and private insurance
<b>Egypt</b>	Yes	9.0%	Tax-based, out-of-pocket, social insurance and private insurance
<b>Fiji</b>	Yes	1.7%	Tax-based and private insurance
<b>France</b>	Yes	5.0%	Tax-based and social insurance
<b>Italy</b>	Yes	Not Available	Tax-based, out-of-pocket and private insurance
<b>Kenya</b>	Yes	0.01%	Tax-based, out-of-pocket, private insurance and social insurance
<b>Lao PDR</b>	No	Not Available	Out-of-pocket and tax-based
<b>Republic of Korea</b>	No	3.0%	Social insurance, tax-based and out-of-pocket
<b>Romania</b>	Yes	3.0%	Out-of-pocket and social insurance
<b>South Africa</b>	Yes	2.7%	Tax-based, private insurance, out-of-pocket and social insurance
<b>USA</b>	Yes	6.0%	Private insurance, tax-based, out-of-pocket and social insurance

Table 3 above demonstrates there are a wide variety of approaches with respect to mental health funding currently in use. However, as the WHO points out in a 2008 policy brief on health systems there is no one correct approach which would be appropriate for or that could be successfully implemented across all 53 European countries.<sup>20</sup>

At the overall level, public policy in EU member states has aimed at preserving the principle of universally accessible health care funded by the state or social insurance, regardless of ability to pay. This has resulted in almost universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure.<sup>21</sup> VHI (Voluntary Health Insurance) should be purchased by people exempt from or excluded from participating in some or all aspects of statutory health insurance on account of being self-employed or high earners, such as in Germany, Austria and Belgium.<sup>22</sup> In the past when there were cutbacks in public expenditure at the same time as sustained economic growth, this generally led to an increased demand for VHI.<sup>23</sup>

### **2.3 Mental health funding and system**

While it is clear the resources and funding available for mental health financing will vary between high resource, medium resource and low resource countries, there are a number of essential criteria that should be taken into account in designing and implementing a successful mental health system, irrespective of the resources available. Furthermore, although it is crucial that the funds allocated to mental health are disbursed in an optimal manner to further the overall objectives of the mental health system and provide maximum support to mental health service users, it is also vital that the mental health system is properly managed in order to ensure the most effective and efficient use of the funds allocated. This section will look at certain of the principal priorities that should be in place to develop a successful mental health funding system.

#### *2.3.1 Mental health prioritisation*

It has been noted that the mental health resources available in countries appear to be as related to measures of general health as are economic or developmental indicators, which would indicate that it is important to ensure that mental health receives a certain level of prioritisation even in low-resource settings.

#### *2.3.2 Funding – integral component of general health financing*

It is critical in terms of mental health financing, especially in countries that do not have a well-articulated mental health system, that funding for mental health financing is seen as an integral component of general health financing with specific and targeted allocations being made for mental health initiatives.<sup>24</sup> Furthermore, mental health financing should reflect new ideas emerging from community based practice in lower and middle income countries (LMICs).<sup>25</sup>

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<sup>20</sup> World Health Organization (2008) *How can chronic disease management programmes operate across care settings and providers?* World Health Organization: Geneva, Switzerland

<sup>21</sup> Mossialos E & Thompson S (2004) *Voluntary health insurance in the European Union*. World Health Organization: Geneva

<sup>22</sup> Ibid

<sup>23</sup> Ibid

<sup>24</sup> Jacob K S et al (2007) *Ibid*

<sup>25</sup> Raja S, Wood S K, de Menil V & Mannarath S C (2010) 'Mapping mental health finances in Ghana, Uganda, Sri Lanka, India and Lao PDR'. *Int J Ment Health Syst.* 4(11)

### 2.3.3 Funding/Resource allocation criteria

A range of factors should be considered during the allocation process including, *inter alia*, the current distribution of resources, priority needs, rurality and the percentage of the population on low income or unemployed.<sup>26</sup> It is also important to allow for other factors, such as the argument that funding allocations work more effectively through decentralization. Where this are considered to be the case, they should be included during the establishment and implementation of the funding disbursement system.<sup>27</sup>

### 2.3.4 WHO AIMS indicators – mental health finance review

Governments should examine the possibility of adapting WHO AIMS indicators to their own particular context in order to review their national mental health finances.<sup>28</sup>

### 2.3.5 Ring-fenced budget

While mental health funding should remain within the overall health and development framework, there should be a dedicated and ring-fenced budget devoted specifically to mental health. These funds should not be leaked into other areas of health funding to cover shortfalls or other needs.<sup>29</sup>

### 2.3.6 Budget – Service Shifts & Transitional Phase

The mental health services' budget should be at or over 10% of the total health budget. This budget should be in the form of protected funding so as to ensure funds are fully transferred during service shifts from institutions to community. Additional ring-fenced mental health funding and resource allocation mechanisms, taking into account and responding specifically to mental health needs, should be put in place during the transitional phase.<sup>30</sup>

### 2.3.7 Tracking budget Information

A system should be established to ensure mental health budget information is tracked. This information should be made publically accessible.<sup>31</sup>

### 2.3.8 Essential system criteria

Those responsible for overseeing mental health policy must remember that the provision of responsive and effective support to mental health service users requires a well trained workforce, effective system governance, and addressing the concerns of administrators and employees.<sup>32</sup>

### 2.3.9 Inter-agency coordination

A mental health system should be established that promotes and ensures effective coordination between all agencies involved in both funding and delivering the required services. This can be achieved in a number of ways. One approach is to foster and ameliorate enhanced coordination across sectors through the employment of a "one-stop shop" model. In this model, one agency might be allocated responsibility for working with mental service users to assist in procuring services, accessing health and social care sector entitlements, obtaining housing assistance and any other social security benefits to which they are entitled and to help service users avail of consumer-directed payments enabling individuals to purchase those services directly which best respond to their needs.<sup>33</sup>

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<sup>26</sup> World Health Organization (2003) *Mental Health Financing: Mental Health Policy and Service Guidance Package*. WHO: Geneva.

[http://www.who.int/mental\\_health/policy/services/essentialpackage1v4/en/index.html](http://www.who.int/mental_health/policy/services/essentialpackage1v4/en/index.html)

<sup>27</sup> Raja S et al. (2010) *Ibid*

<sup>28</sup> *Ibid*

<sup>29</sup> Jacob K S et al (2007) *Ibid*

<sup>30</sup> McDaid D (2005) *Key issues in the development of policy and practice across Europe*. European Observatory on Health Systems and Policies/WHO: Geneva

<sup>31</sup> Raja S et al. (2010) *Ibid*

<sup>32</sup> McDaid D (2005) *Ibid*

<sup>33</sup> *Ibid*

## **2.4 Mental health funding – case studies**

This section will examine mental health funding systems in a number of countries from Europe and other regions.

### **2.4.1 Netherlands**

The Netherlands has a private-insurance/managed-competition model which includes social insurance schemes for the elderly and poor. The option of private insurance is available for the more affluent. However, there are problems associated with this approach including inequities of service based on income status, rising costs, and rationed health services. In 2006, a mandatory scheme was established requiring the purchase of health insurance policies from private insurers. Adults pay a set premium to their chosen insurer for a basic package of services and the government collects about 6.5% in payroll taxes from all employees to fund health services covered by the state, such as those for children. The government also subsidizes low wage earners and insurance companies for taking on high-risk individuals.<sup>34</sup> The Netherlands spent 12% of its total GDP on health in 2010. This was the second highest of all OECD countries and well above the 9.5% average. Health spending per capita was also high and ranked fourth highest in the OECD in 2010 behind the US, Norway and Switzerland. 85.7% of health spending in the Netherlands was financed by public sources, well above the OECD average of 72.2%<sup>35</sup>

### **2.4.2 Israel**

Since the introduction of National Health Insurance (NHI) in 1995, Israel has had a universal health insurance system that is predominantly tax-financed and that ensures access to a broad package of benefits. All residents are entitled to enrol in any of the four competing, non-profit health plans.<sup>36</sup>

The health plans receive capitation payments from the government, which reflect the number of members in each plan and their age mix. Many residents also purchase supplemental insurance, from either the health plans or commercial insurers. Approximately 31% of total health care expenditures are financed privately. This figure includes household payments for supplemental insurance, out-of-pocket payments for services not covered under NHI, co-payments for pharmaceuticals and specialist visits provided under NHI, and visits to private physicians.<sup>37</sup>

Israel spends around 7.5% of its GDP on national health, below the 9.5% OECD average. Israel also ranks below the average OECD capita spending on health with spending of US\$2,165 in 2009 (adjusted for purchasing power parity) against an average of US\$3,268. 60.5% of all health spending was financed by the State, well below the 7.2% OECD average.<sup>38</sup>

It is important to note that the mental health system is broadly separate from the physical health system in terms of financing, planning, organization, and practice setting. These expenses are primarily financed by general tax revenues. The government is the largest provider of mental health services, operating about half of the psychiatric hospitals and the largest network of community mental health centres.<sup>39</sup>

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<sup>34</sup> Johnson T (2009) *Ibid*

<sup>35</sup> OECD (2012) *OECD Health Data 2012: How Does the Netherlands Compare?*  
<http://www.oecd.org/netherlands/BriefingNoteNETHERLANDS2012.pdf>

<sup>36</sup> Rosen B, Nirel N, Gross R, Bramali S & Ecker N (2008) 'The Israeli Mental Health Insurance Reform'. *J Ment Health Policy Econ.* 11:201-208

<sup>37</sup> *Ibid*

<sup>38</sup> OECD (2012) *OECD Health Data 2012: How Does Israel Compare?*  
<http://www.oecd.org/israel/BriefingNoteISRAEL2012.pdf>

<sup>39</sup> Rosen B et al (2008) *Ibid*

The National Health Insurance Law includes a lengthy inventory of mental health services the government is expected to supply. However, it overlaps with a list of mental health services that the health plans should provide, thus leading to confusion about the allocation of responsibility between the government and the health plans. This can make it difficult for those requiring mental health care to realize their rights to care.<sup>40</sup>

#### 2.4.3 The United States

Historically, it was found that while only a small proportion of people used mental health care services, the costs associated were very high. Consequently, employers placed limits on mental health benefits to try and make the insurance risk more manageable. The general strategies employers have used to manage health care costs include cost sharing, utilization review, managed care, and the packaging of provider services. Employers' cost management strategies may be restricted, however. Five states have mental health parity laws, though three of the states - Rhode Island, Maine, and New Hampshire - apply these laws only to the seriously mentally ill. In addition, 31 states have mandated that mental health benefits be provided. However, these mandates only apply to insured plans not self-insured employer plans, which were exempted from state regulation of health plans under the 1974 Employee Retirement Income Security Act (ERISA). A number of studies in the 80s and early 90s examined the impact of mental health parity on health insurance premiums in a "typical" preferred provider organization and on the uninsured. In general, the studies concluded that mental health parity could increase health insurance premiums, decrease health insurance coverage for non-mental health related illnesses, and increase the number of uninsured individuals. All studies of mental health parity and mandated benefits in general, assume a strong likelihood that increased health benefit costs would be passed along to workers through higher cost sharing for health insurance, lower wage growth, or lower growth in other employee benefits.<sup>41</sup> Across the three measures of out-of-pocket expenditures as a share of income the estimates are under 10% for most groups. However, there is some variation in the burden across groups with people who are older, uninsured, or from a minority spending a larger share of their out-of-pocket income. The estimated mean out-of-pocket share of total expenditures for the mental health group as a whole is 25%.<sup>42</sup>

The benefits of the U.S. privately insured population under 65 leave most people at risk of high out-of-pocket costs in the event of a serious mental illness. Moreover, the generosity of existing mental health benefits varies widely across subgroups, particularly across firm size. Significantly lower out-of-pocket costs occur when simulating full parity coverage. However, research shows those with less generous mental health coverage usually also have less generous physical health coverage. Parity would substantially increase the generosity of mental health coverage for most of the privately insured population. The wide variation in the generosity of existing mental health benefits suggests the likelihood of differential impacts from a parity perspective.<sup>43</sup> Those with limited physical health coverage have also tended to be at significant financial risk for catastrophic mental illness.<sup>44</sup>

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<sup>40</sup> Ibid

<sup>41</sup> Fronstin P (1997) 'Issues in mental health care benefits: the costs of mental health parity'. *EBRI Issue Brief*. 182:1-14.

<sup>42</sup> Ringel J S, & Sturm R (2001) 'Financial Burden and Out-of-Pocket Expenditures for Mental Health Across Different Socioeconomic Groups: Results from HealthCare for Communities'. *J Ment Health Policy Econ*. 4(3):141-150

<sup>43</sup> Zuvekas S H, Banthin J S & Selden T M (2001) 'How would mental health parity affect the marginal price of care?' *Health Serv Res*. 35(6):1207-1227 & *Bull World Health Organ*. 80(2):134-142

<sup>44</sup> Zuvekas S H, Banthin J S & Selden T M (1998) 'Mental health parity: what are the gaps in coverage?' *J Ment Health Policy Econ*. 1(3):135-146



A 2007 study undertaken by Himmelstein *et al* analysed 2,314 random bankruptcy filers in the U.S. and estimated that medical expenses contributed to 62.7% of the personal bankruptcies. This was a rise of almost 16% from 46.2% found in their previous 2001 study. Most worryingly, of this 62.1%, some 75% actually had health insurance.<sup>45</sup>

Parity legislation has not led to significant changes in benefit design. In fact, the high ratio of out-of-pocket payments relative to total mental health care expenditures is consistent with a limited role of parity legislation.<sup>46</sup>

Today, the U.S. health care system is a mix of employer-provided insurance, government-provided Medicare and Medicaid, and state-provided high-risk pools for the "medically uninsurable," and out-of-pocket payments by the uninsured, which do not fall into any of these programs.<sup>47</sup> Health spending accounted for 17.6% of GDP, the highest in the OECD, almost double the OECD average of 9%. The U.S. was by far the highest spender by capita on health, disbursing US\$8,233, nearly US\$3,000 more than the next highest Norway (US\$5,388) and over 2.5 times the OECD average of US\$3,268. The U.S. was one of only three countries, together with Mexico and Chile, where less than 50% of total healthcare costs were publicly funded with its 48.2% of public health funding well under the OECD average of 72.2%.<sup>48</sup>

#### 2.4.4 New Zealand

The public sector proportion of New Zealand's total health expenditure fell from 87% in 1983/84 to 77% in 1997/98 in real per capita terms.<sup>49</sup> There were also increases in both out-of-pocket payments and membership of private health insurance funds over the period from 1983/84 to 1997/98.<sup>50</sup> However, by 2010, New Zealand's public share of expenditure on health had risen to 83.2%, more than 10% above the OECD average.<sup>51</sup> Total health spending as a percentage of GDP stood at 10.1% in 2010, 0.6% above the OECD average of 9.5%. However, New Zealand ranked below the average in per capital health spending, disbursing US\$3,022 (adjusted for purchasing power parity) against the OECD average of US\$3,268.

#### 2.4.5 Brazil

In Brazil, the current financial model was established after a right to free health care was codified in 1988 in the country's constitution. With a population of 191 million, Brazil spends 9% of its GDP on health, just under the OECD average of 9.5%. According to the OECD, health spending tends to rise with income and it is therefore not surprising that Brazil spends well below the OECD average per capita, US\$1,028 (adjusted for purchasing power parity) in 2010 against the OECD average of US\$3,022. In Brazil, the public sector accounted for 47% of health funding well below the OECD average of 72.2%.

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<sup>45</sup> Himmelstein D U, Thorne D, Warren E & Woolhandler S (2007) 'Medical Bankruptcy in the United States, 2007: Results of a National Study'. *The American Journal of Medicine*. 122:8.  
[http://www.pnhp.org/new\\_bankruptcy\\_study/Bankruptcy-2009.pdf](http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf)

<sup>46</sup> Ringel J S & Sturm R (2001) *Ibid*

<sup>47</sup> Johnson T (2009) *Ibid*

<sup>48</sup> OECD (2012) *OECD Health Data 2012: How Does the U.S. Compare?*  
<http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf>

<sup>49</sup> Hopkins S & Cumming J (2001) 'The impact of changes in private health expenditure on New Zealand households.' *Health Policy*. 58(3):215-29

<sup>50</sup> Hopkins S & Cumming J (2001) *Ibid*

<sup>51</sup> OECD (2012) *OECD Health Data 2012: How Does New Zealand Compare?*  
<http://www.oecd.org/newzealand/BriefingNoteNEWZEALAND2012.pdf>



The private sector, which comprises both private voluntary health insurance and private providers, operates alongside the public system.<sup>52</sup> In the private sector, people pay private providers using private health insurance or out-of-pocket payments. This approach risks duplicating the public health system's services.<sup>53</sup> According to a 2008 WHO paper, about 70% of Brazilians access government health services, with about 30% supplementing these services with additional private insurance. The public health service is financed through federal tax revenues but is largely administered by state and local governments.<sup>54</sup>

#### 2.4.6 Taiwan

Taiwan has a national insurance model, providing health coverage to approximately 99% of the population in 2000 and spends about 6 per cent of GDP on health. Its compulsory system is financed largely through shared deductions from employers and employees on a sliding income-based scale, while the government funds a portion of services from the general budget. This system has one of the lowest administrative costs worldwide and uses a smart card system, enabling everything from making payments to disease monitoring, abuse detection and instant medical histories. The system provides most protection for the sick and elderly as everyone is included in the same risk pool. However, the long-term financial viability of Taiwan's system is a concern. In 2008, for example, the program ran a monthly \$30 million deficit but the government was unwilling to raise premiums.<sup>55</sup>

The Taiwanese Department of Health establishes the health policy and oversees the operations of the Bureau of National Health Insurance. The benefits package for Taiwanese citizens is a comprehensive one and comprises a range of services including inpatient and outpatient services, dental services, traditional Chinese medicine, prescription drugs, diagnostics, mental health treatment, home health care as well as certain preventive health services. Beneficiaries are expected to pay premia to enrol in this scheme.<sup>56</sup>

### 2.5 Conclusion

The amount of public spending on health care varies greatly from country to country. However, there are some clear trends. Firstly, countries with fewer resources tend to expend a lower percentage of their GNP on health care than relatively wealthier countries. Secondly, different regions tend to favour different models with, for example, Europe generally preferring social health insurance models. Thirdly, there is a wide range of health funding models with the model chosen frequently depending as much on political factors as on economic criteria. The fact that different countries chose disparate funding models is not necessarily a negative thing. As discussed in Section 2.2 above and as the WHO advise there is no one *de facto* funding model that is always right. However, it is essential that the funding model chosen is selected on the needs of the mental health service and its users and not on political grounds.

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<sup>52</sup> Johnson T (2009) *Ibid*

<sup>53</sup> Ugá M A D & Santos I S (2007) 'An Analysis Of Equity In Brazilian Health System Financing'. *Health Affairs*. 26(4)1017-1028

<sup>54</sup> Johnson, T. (2009) *Ibid*

<sup>55</sup> *Ibid*

<sup>56</sup> Center for Health Market Innovations (2012) *Health Financing in Taiwan*. <http://healthmarketinnovations.org/program/health-financing-in-taiwan>

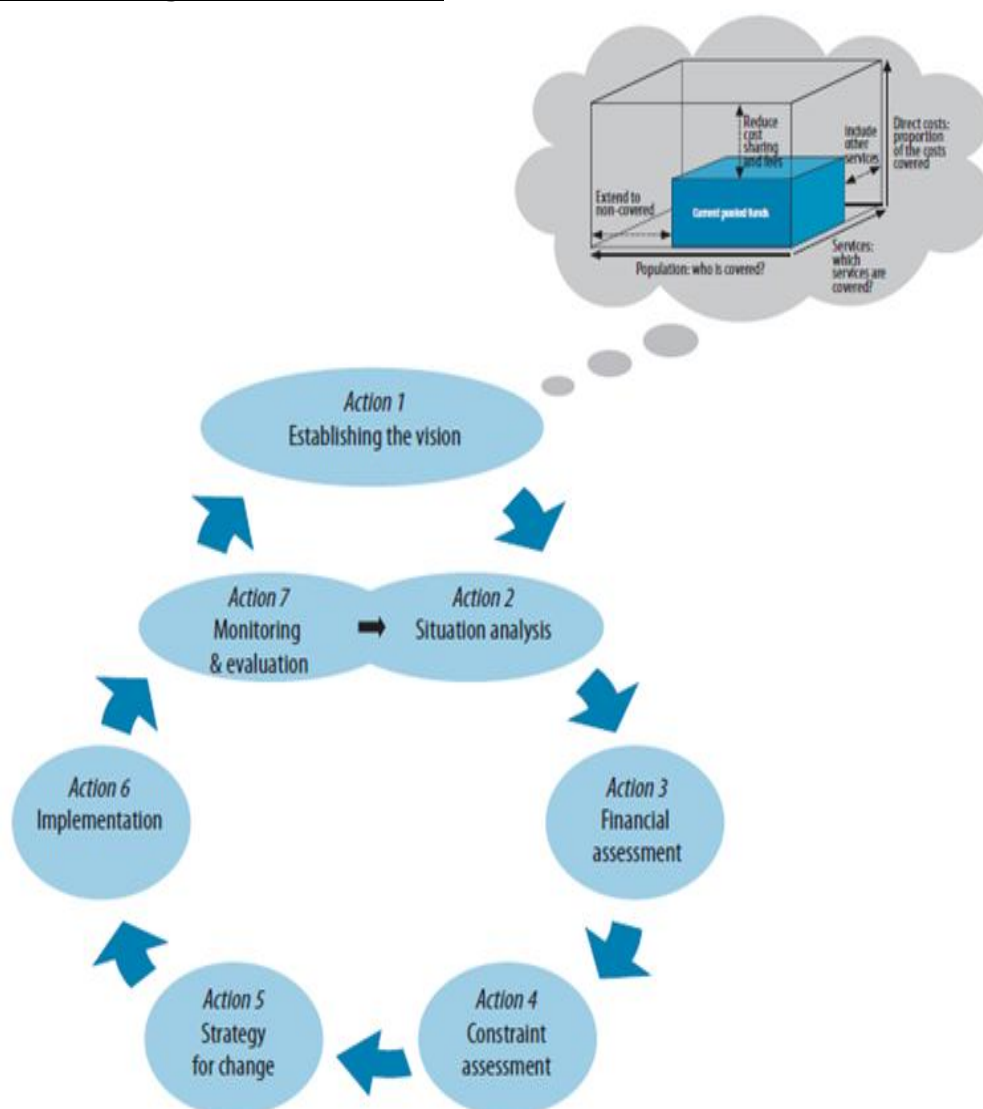
### 3. Funding System Standards

This chapter will examine the standards for health system financing, as recommended by the WHO, and certain of the discussions with respect to these recommendations. The unique characteristics of mental health in terms of financing that make it critical for governments to ensure their citizens are adequately covered for mental health treatment compared will also be analysed. The chapter will conclude with a more in-depth look at social health insurance and how well it provides cover for those who require mental health care.

#### 3.1 WHO on health system financing and structure

The WHO has provided a very useful compendium of the more important components and criteria that should be taken into account when developing and implementing an effective mental health care system and funding structure. It is important to look at both the system and funding methods together in order to identify and develop an effective mental health funding system that responds and meet the needs of the mental health system for which it is designed. Figure 1 below outlines the health financing decision process.<sup>57</sup>

**Figure 1: Health Financing Decision Process**



<sup>57</sup> World Health Organization (2010) *Ibid*

### 3.1.1 Importance of community-based mental health care systems

Health systems are core to the delivery of evidence-based mental health care.<sup>58</sup> In this respect. The WHO has outlined the rationale for these together with the need to construct community-based mental health systems and services<sup>59</sup> and identified the following key components in developing an effective community based system:

- i) Treatment for mental disorders should be provided through primary care
- ii) Increased accessibility to essential psychotropic medication should be ensured
- iii) Care should be provided in the community
- iv) The public should be educated on mental health
- v) Communities, families and consumers should be involved in the mental health system
- vi) National policies, programmes, and required legislation on mental health should be developed and promptly enacted
- vii) The required human resource expertise should be developed
- viii) Links with other relevant sectors should be established
- ix) Community mental health should be effectively monitored
- x) Relevant research should be supported<sup>60</sup>

### 3.1.2 Universal health coverage

In 2005, the Member States of the WHO made a commitment to work towards developing health financing systems that would ensure all their citizens could access the health services they require and would not suffer financial hardship from out-of-pocket expenses.<sup>61</sup> This goal was defined as ensuring universal coverage or universal health coverage for all.<sup>62</sup> To ensure universal health coverage, the WHO suggested countries would need to ensure they were able to raise sufficient funds, reduce reliance on direct payments to finance services, and improve efficiency and equity.<sup>63</sup>

One means by which developing countries could be assisted in raising the required funds to ensure universal coverage would be through the increasing of development aid to these states.<sup>64</sup> If the UN international development assistance target of 0.7% gross national income was met, supplementary funds would be available for lower income countries that could be allocated to universal coverage.<sup>65</sup> Since the signing of the Millennium Declaration in September 2008, donor commitments for health have increased more than fourfold. However, lower income countries still have to find almost 75% of their health funding from domestic sources.<sup>66</sup>

### 3.1.3 Lower income countries potential funding mechanisms

Lower income countries can raise income from domestic sources in a variety of ways including more efficient revenue collection, reprioritizing government budgets, innovative financing (levy on foreign transactions, taxes on air tickets, taxes on products harmful to health) diaspora bonds and solidarity levies. The Taskforce on Innovative International Financing for Health Systems has calculated that about 5-6% of GDP would be required to ensure the entire population has access to government financed health services.<sup>67</sup>

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<sup>58</sup> World Health Organization (2000) *World Health Report 2000: Health systems: improving performance*. WHO: Geneva

<sup>59</sup> World Health Organization (2001a) *World Health Report 2001: Mental health: new understanding, new hope*. WHO: Geneva

<sup>60</sup> Jacob K S et al (2007) *Ibid*

<sup>61</sup> World Health Organization (2005) 'Resolution WHA 58.33: Sustainable health financing, universal coverage and social health insurance'. In: *Fifty- eighth World Health Assembly, Geneva, 16–25 May 2005*. WHO: Geneva

<sup>62</sup> World Health Organization (2010) *Ibid*

<sup>63</sup> *Ibid*

<sup>64</sup> *Ibid*

<sup>65</sup> Fryatt R & Mills A (2010) 'Taskforce on Innovative International Financing for Health Systems: showing the way forward'. *Bull World Health Organ.* 88:476–477

<sup>66</sup> Evans D B & Etienne C (2010) 'Health systems financing and the path to universal coverage'. *Bull World Health Organ.* 88:402

<sup>67</sup> World Health Organization (2009) *Constraints to scaling up Health Related MDGs: Costing and Financial Gap Analysis*. WHO: Geneva [http://www.who.int/choice/publications/d\\_ScalingUp\\_MDGs\\_WHO\\_report.pdf](http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf)

#### 3.1.4 Required prepayment

Arguably, the most efficient way to raise funds from domestic sources is through required prepayment<sup>68</sup> with the pooling of funds across the population to spread the financial risk of illness together with health financing systems to ensure these funds are used efficiently and equitably.<sup>69</sup> The WHO has also recommended a system of cross subsidization between multiple pools so that funds are transferred between people enrolled with few health needs and those with people requiring more services.<sup>70</sup>

#### 3.1.5 Private expenditure

According to Fryatt and Mills an implicit recommendation arising from the work of the Task Force on Innovative International Financing of Health Systems,<sup>71</sup> is that a significant proportion of funding should come from private expenditure by expanding private (profit-seeking) investment through the use of public funds to mitigate risk.<sup>72</sup> Pools created to cater for health/mental health needs should have a certain minimum number of members, as those containing too few members will not be viable in the long run and risk getting wiped out after a few expensive illnesses.<sup>73</sup>

#### 3.1.6 Reducing capital flight

McCoy and Brikci recommend low income countries reduce capital flight through the promotion of a more effective tax policy and by improving their tax collecting systems, At the same time, they should adopt a performance based system, as a lack of public service investment combined with an unregulated commercially driven health system could deteriorate the situation.<sup>74</sup>

#### 3.1.7 Direct payment or cost sharing

While all countries have direct payment or cost sharing it has been recommended they should be limited to 15-20% of total health expenditure to ensure that the incidence of financial catastrophe and impoverishment fall to negligible levels.<sup>75</sup> Recent research would also appear to indicate that out-of-pocket payments (user fees) are an inefficient and inequitable health financing mechanism.<sup>76</sup>

#### 3.1.8 Exempting consumers on economic criteria

Attempts to exempt people from fees on economic criteria have tended to have a poor record of success in low-resource countries.<sup>77</sup> In Sub-Saharan Africa informal, low accuracy and low-cost means testing was trialled at the point of service. In Ethiopia, waived fees were paid from community association funds. Local community associations issued free health care certificates but did not issue them freely. There was low leakage and possibly inadequate coverage among the poor. In Zimbabwe, leakage was high, because the income threshold was high and set by central bodies. Facilities in rural areas had to determine eligibility since pay slips are not used. In general the systems applied to date in Africa have suffered from relatively high leakage.<sup>78</sup>

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<sup>68</sup> World Health Organization (2010) *Ibid*

<sup>69</sup> Evans D B & Etienne C (2010) *Ibid*

<sup>70</sup> World Health Organization (2010) *Ibid*

<sup>71</sup> Fryatt R & Mills A (2010) *Ibid*

<sup>72</sup> McCoy D & Brikci N (2010) *Ibid*

<sup>73</sup> World Health Organization (2010) *Ibid*

<sup>74</sup> McCoy D & Brikci N (2010) *Ibid*

<sup>75</sup> World Health Organization (2010) *Ibid*

<sup>76</sup> Yates R (2009) 'Universal health care and the removal of user fees'. *Lancet*. 373:2078-81

<sup>77</sup> Yates R (2010) 'Women and children first: an appropriate first step towards universal coverage'.

*Bulletin of the World Health Organization*. 88:474-475

<sup>78</sup> Willis C Y & Leighton C (1995) 'Protecting the poor under cost recovery: the role of means testing'. *Health Policy Plan*. 10(3):241-56

### 3.1.9 User fees

A 2008 Japanese Government taskforce recommended that 'developing' countries' remove user fees, starting initially with services relevant to Millennium Development Goals (MDG) 4, 5 and 6.<sup>79</sup> Yates argues for the total abolition of user fees starting with women and children.<sup>80</sup> He argues that providing services free at the point of delivery would be an efficient means of channelling people with a greater ability to pay into the private sector, thus making the benefit incidence of public health financing more equitable and compatible with all other financing mechanisms that rely on pre-payment methods.<sup>81</sup> Others argue that user fees are a means of making patient payments more transparent and thereby countering unofficial and under the table payments.<sup>82</sup>

### 3.1.10 Joint federal and state financing

Health care can be jointly financed by federal and state (or provincial) governments. Some countries use the general tax approach but decentralize responsibility to local government.<sup>83</sup>

### 3.1.11 Loss of income and transport costs

Loss of income and transport cost can be an impediment in accessing care. These can be overcome by conditional cash transfers, vouchers and refunds as well as micro-credit schemes.<sup>84, 85</sup>

### 3.1.12 Inefficient and inequitable use of resources

According to WHO 20% to 40% of all health spending is wasted through inefficient and inequitable use of resources.<sup>86</sup> According to the WHO's World Health Report, health systems everywhere could make better use of resources, whether through better procurement practices, broader use of generic products, better incentives for providers, eliminating waste and corruption, reducing medical errors, increasing hospital efficiency, getting more out of newer technologies and health services, critically assessing what services are needed or streamlined financing and administrative procedures.

When purchasing services, countries would be better off either pursuing active purchasing based on population health needs or strategic purchasing based on the particular country's ability to collect, monitor and interpret information and enforce standards of quality and efficiency.<sup>87</sup>

### 3.1.13 Service fees

Fees for services can result in over servicing those who can pay. Many governments have introduced capitation at the primary care level and case based payments to try and avoid this.<sup>88</sup> The existence of service fees can serve as an incentive for General Practitioners not to participate in coordinated care programmes without pay increases as well as encouraging consumers to seek a substantial decrease in their premiums.<sup>89</sup>

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<sup>79</sup> Task Force for Global Action for Health System Strengthening (2009) *Global Action for Health System Strengthening. Policy recommendations to the G8*. Japan Center for International Exchange: Tokyo. [www.jcie.org/researchpdfs/takemi/full.pdf](http://www.jcie.org/researchpdfs/takemi/full.pdf)

<sup>80</sup> Yates R (2009) *Ibid*

<sup>81</sup> Yates R (2010) *Ibid*

<sup>82</sup> Jowett M & Danielyan E (2010) 'Is there a role for user charges? Thoughts on health system reform in Armenia'. *Bull World Health Organ* 2010. 88:472-473.

<sup>83</sup> World Health Organization (2003) *Mental health financing*. WHO: Geneva. [http://www.who.int/mental\\_health/resources/en/Financing.pdf](http://www.who.int/mental_health/resources/en/Financing.pdf)

<sup>84</sup> Leatherman S & Dunford C (2010) 'Linking health to microfinance to reduce poverty'. *Bull World Health Organ* 2010. 88:470-471.

<sup>85</sup> World Health Organization (2010) *Ibid*

<sup>86</sup> *Ibid*

<sup>87</sup> *Ibid*

<sup>88</sup> *Ibid*

<sup>89</sup> Zweifel P (2011) 'Swiss experiment shows that physicians, consumers want significant compensation to embrace coordinated care'. *Health Aff.* 30(3):510-518

### 3.1.14 Performance based funding

Performance based funding has as its primary drive the aim of improving health-worker performance, where it is funded from public finances. However, it ignores the human dimension to development, thus acting as a disincentive to patient centred care.<sup>90</sup>

### 3.1.15 Varying outcomes

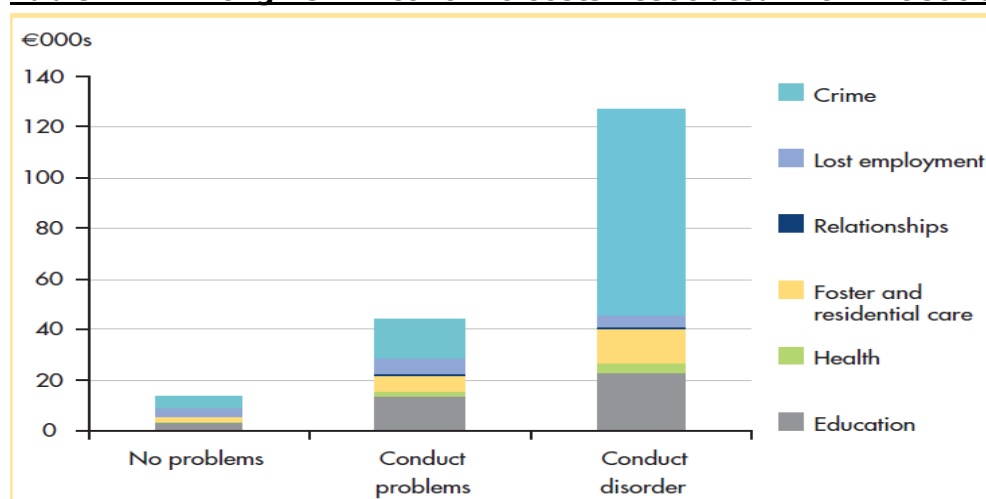
As noted above, health systems are core to the delivery of evidence-based mental health care.<sup>91</sup> Countries with similar levels of health expenditure achieve strikingly different health outcomes from their investments due to differing policy decisions.<sup>92</sup>

## 3.2 Unique case of mental health

Mental health is a unique case in terms of health systems, given its broad impact on all aspects of a patient's life including physical health, family relationships and social networks, employment status and contact with the criminal-justice system. Mental Health therefore requires a coordinated multi-sectoral approach in the formulation of policies and the development of services, which take into account culture, disposable resources and local structures.<sup>93, 94</sup>

Table 4 below demonstrates how mental health concerns impact across a wide range of social concerns by evaluating the long term economic costs of mental health problems arising from the required long term follow up of antisocial children.<sup>95</sup>

**Table 4: Long Term Economic Costs Associated with Antisocial Children**



As a general rule and although it may be difficult to achieve, governments should strive to achieve mandatory coverage for mental health, even if the coverage is limited.<sup>96</sup>

<sup>90</sup> Ireland M, Paul E & Dujardin B. (2011) 'Can performance based financing be used to reform health systems in developing countries?' *Bulletin of the World Health Organization*. 89(9):695-698.

<sup>91</sup> World Health Organization (2000) *Ibid*

<sup>92</sup> *Ibid*

<sup>93</sup> McDaid D (2005) *Ibid*

<sup>94</sup> Jenkins R (2002) *Developing a National Mental Health Policy*. Psychology Press: Hove, UK

<sup>95</sup> Scott S, Knapp M, Henderson J & Maughan B (2001) 'Financial cost of social exclusion: follow-up study of antisocial children into adulthood'. *British Medical Journal*. 323:191-196

<sup>96</sup> World Health Organization (2003) *Ibid*

If a government accounts for 70-80% of total expenditure on health, as occurs in many OECD Member States, mental health priorities can be directly implemented through the budget, with only minor offsetting effects due to private spending. If, however, a government provides only 20-30% of total financing and there is little insurance coverage, mental health care is likely to be neglected in comparison with other areas of health care given the greater reliance on out-of-pocket spending.<sup>97</sup>

Out of pocket payments place an excessive and unplanned burden on families, especially in low-income countries, and diminish the resources available for mental health care the more one moves away from prepayment.<sup>98</sup> In low income countries with low prepayment and/or difficulties raising revenue or extending social insurance community, financial schemes may be a way forward.<sup>99</sup>

Table 5 outlines WHO recommendations on mental health service provision in low-resource, medium resource and high resource countries.<sup>100</sup>

**Table 5: Recommended Mental Health Services**

Countries	Funding Sources
<b>Low Resource</b>	Should focus on establishing and improving mental health services within primary care services, using specialist services as a back-up
<b>Medium Resource</b>	Should also seek to provide related components such as outpatient clinics, community mental health care teams, acute inpatient care, long-term community-based residential care and occupational care
<b>High Resource</b>	In addition to the above, they should also provide forms of more differentiated care such as specialized ambulatory clinics and community mental health care teams, assertive community treatment, and alternatives to acute inpatient care, long-term community residential care and vocational rehabilitation

### 3.3 Social Health Insurance

Given the widespread use of Social Health Insurance (SHI) in Europe and globally, if not in income poor countries, this section will examine SHI in more detail. Figure 2 below depicts the relationship between various actors in countries with a Social Health Insurance (SHI) system.<sup>101</sup>

<sup>97</sup> Ibid

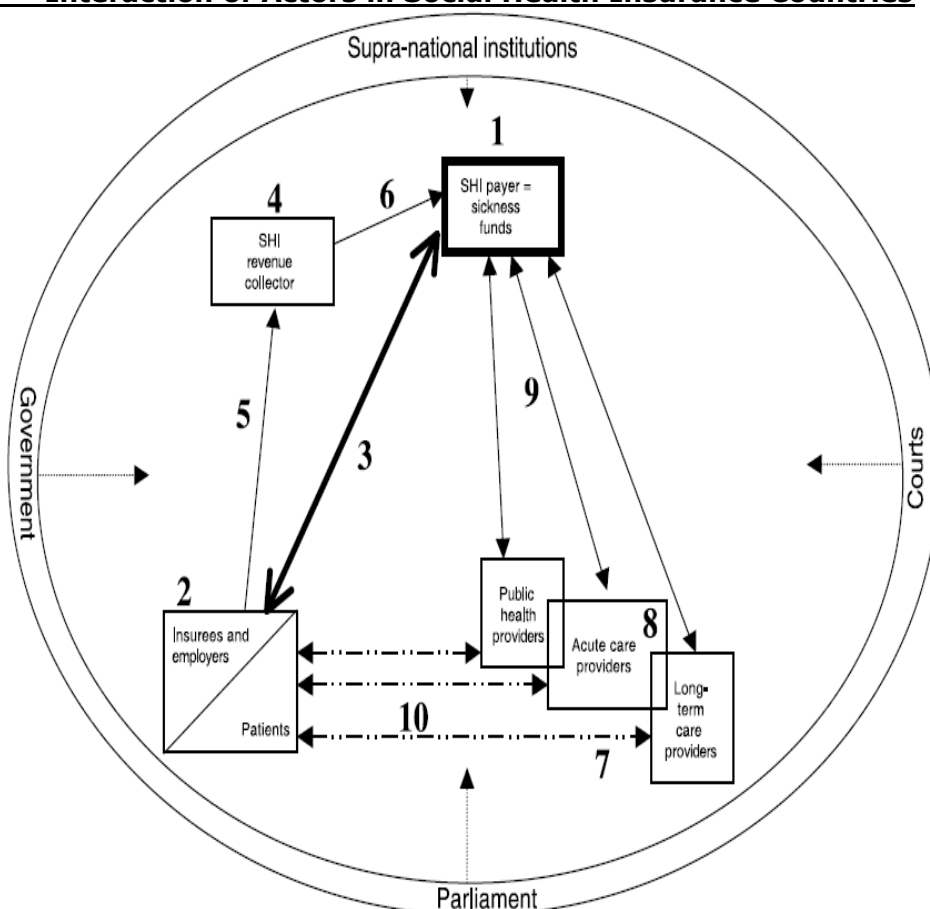
<sup>98</sup> Ibid

<sup>99</sup> Ibid

<sup>100</sup> World Health Organization (2001b) *Atlas: Country Profiles on mental health resources 2001*. WHO: Geneva

<sup>101</sup> Busse R, Saltman R B, Dubois H F W (2004) 'Organisation and financing of social health insurance systems: current status and recent policy developments.' In *Social Health Insurance systems in Western Europe*. Saltman R B, Busse R & Figueras J (eds). Open University Press: Maidenhead, UK

**Figure 2: Interaction of Actors in Social Health Insurance Countries**



A number of countries have several sickness funds complete with management and decision making boards. However, in general, decision making powers are limited by legislation and in many countries the sickness fund is supplemented by a national umbrella organization with up to 84% of the population covered by sickness funds.<sup>102</sup>

At the point of making payment from the sickness fund to the physicians/service providers, factors determining performance assessment such as a potential shirking at tasks, risk averseness and random shocks cannot be fully verified based on observable outcomes. Performance contracting or incentive contracts are used to balance the challenges of providing high quality care while containing costs. There is evidence suggesting that the implementation of financial incentives within contractual relationships in managed care settings can improve quality of care.<sup>103</sup>

Most SHI countries have a combination of private and public service provision but this is often associated with short term budget goals or political interests and can lead to variations in cost, quality and patient coverage. The division between private provision in primary care and public provision in inpatient care created incentives for various forms of cost shifting in either direction.<sup>104</sup>

<sup>102</sup> Ibid

<sup>103</sup> Ibid

<sup>104</sup> Ibid



European style managed care models have proven difficult to implement in many instances due to, for example, the difficulty encountered by physicians in coping with double agent roles and the patient's desire to see any available provider through the regular SHI contracts. The latter was particularly noticeable in Switzerland. Moreover, insurers claim that managed care models, given their particular format, are only appropriate in urban settings.<sup>105</sup>

In certain SHI countries, all physicians must be contracted by SHI insurers while in others the option of selective contracting is preferred. This does not result in a restriction of access to any physician as visits are associated with patient reimbursement and substantial co-payments. Again, some SHI countries do collective contracting while others set prices centrally.

Doctors and other health professionals often negotiate target income with reference to certain income levels as in the Netherlands where this is not supposed to exceed that of the higher income bracket civil servants.<sup>106</sup>

In SHI countries, ambulatory health care tends to be provided for on a fee for service basis. The Sickness Fund covers basic GP care packages with hospital care organized in a decentralised manner without use of benefit catalogues. Certain countries such as Germany have implemented a DRG system which should entail benefits being catalogued. Countries such as Switzerland and Germany sanction the reimbursement of medication through SHI provided drugs that have been licensed by the European Medications Evaluation Agency or national equivalent. On the other hand, countries such as France, Israel and Netherlands have positive lists of the drugs covered.<sup>107</sup>

Although emergency treatment is generally covered, dental coverage is usually restricted under SHI but can be obtained by disbursement of a fee for a particular service or via private insurance schemes.<sup>108</sup> There is a general trend to contract the provision of services in primary and secondary care from the private sector and the public provision of services for hospital care from government or private (non-profit) providers.<sup>109</sup>

People with mental illness frequently require long term care (LTC) provided in the form of support in activities of daily living (ADL) and or instrumental activities in daily living (IADL). However, due to a decline in informal cultural arrangements, involving relatives and neighbours, there has been an increased government interest in providing these supports socially.<sup>110</sup> Figure 3 below illustrates how mental health services may be mapped. This system can be funded by a variety of different mechanisms including social health insurance, private health insurance and so forth. Therefore, SHI or any indeed any other funding mechanism should not be rejected without taking into account the economic resources of the country concerned as well as other relevant political and social variables.

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<sup>105</sup> Ibid

<sup>106</sup> Ibid

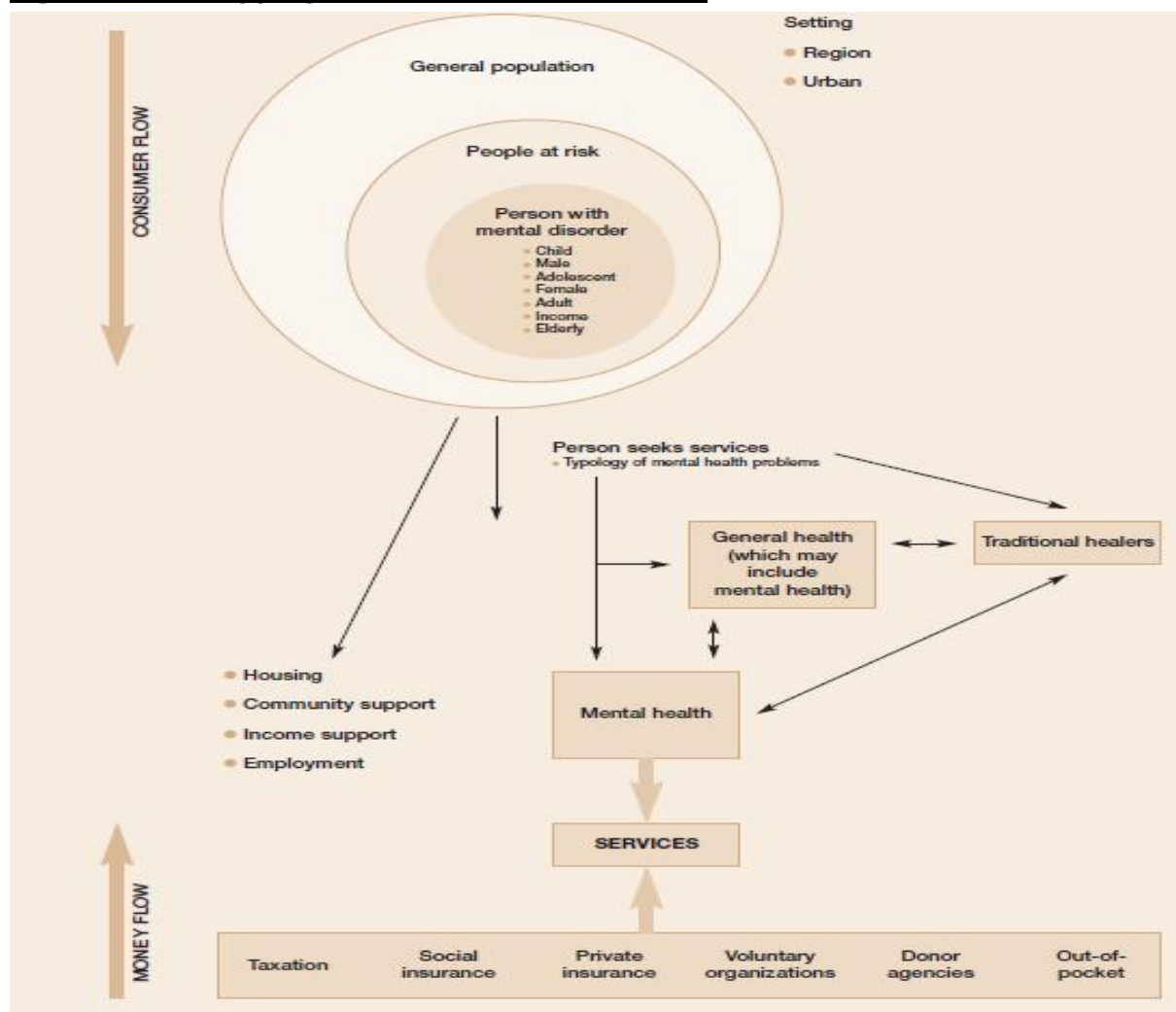
<sup>107</sup> Gibis B, Koch-Wulken P W & Baltman J (2004) 'Shifting criteria for benefit decisions in social health insurance systems'. In *Social Health Insurance systems in Western Europe*. Ibid

<sup>108</sup> Ibid

<sup>109</sup> Hoffmarcher M M & Durand-Zaleski I (2004) 'Contracting and paying providers in social health insurance systems'. In *Social Health Insurance systems in Western Europe*. Saltman R B, Busse R & Figueras J (eds). Open University Press: Maidenhead, UK

<sup>110</sup> de Roo A, Chambaud L, Güntert B J (2004) 'Long term care in social health insurance systems'. In *Social Health Insurance systems in Western Europe*. Saltman R B, Busse R & Figueras J (eds). Open University Press: Maidenhead, UK

**Figure 3: Mapping Mental Health Services.<sup>111</sup>**



### 3.4 Conclusion

The WHO guidelines provide a very useful set of guidelines and principles that countries can avail of in order to optimise their mental health funding model irrespective of their level of resources. It is important to remember when designing a funding model for mental health that mental health is unique in terms of health care needs. If there is low public expenditure on mental health, it often tends to be relatively neglected compared to other health treatments. If inadequately resourced, mental health problems can lead to expenses in other sectors of the economy and society. SHI appears to offer the best financial protection from high out-of-pocket expenses and financial burden for those who are eligible. Families with private non group coverage have the highest odds of being in the high-expense and high-burden categories for all incomes. For higher-income families, having a family member in fair or poor health is a significant risk factor for high out-of-pocket expenses and financial burden. Having a higher penetration of health maintenance organizations in an area appears to lower the odds of being in the high-burden category for all families.<sup>112</sup>

<sup>111</sup> World Health Organization (2003) *Ibid*

<sup>112</sup> Shen Y C & McFeeters J (2006) 'Out-of-pocket health spending between low-and higher-income populations: who is at risk of having high expenses and high burdens?' *Med Care*. 44(3):200-9

## 4. Health System Financing and Impact on Various Social Categories

The first section of this chapter examines mental health system funding from the point of view of various categories of mental health service users and their families. In the second section, the issue of the economic cost of mental health will be analysed. It is critical when discussing the appropriate level of funding to be allocated to mental health that not only is the cost of providing mental health services is looked at but also the cost of **not** providing adequate funding to deliver the required mental health services.

### 4.1 Mental health funding and impact on service users

#### 4.1.1 Financial burden on mental health service users

An analysis of Medical Expenditure Panel Survey (MEPS) data in the United States by Banthin *et al* from the revealed that rising out-of-pocket expenses and stagnant incomes increased the financial burden of health spending for families between 2001 and 2004. The financial burden on those with non-group coverage increased significantly by over one-third. Despite the evidence demonstrating the benefit for increased cost sharing in private insurance plans, the results did not show that privately insured people had to pay a higher share of their total health care bill in 2004 compared to 2001. However, the financial burden has increased to the point at which private insurance is no longer a viable option for an increasing number of families.<sup>113</sup> These findings corroborate the recent experience in Ireland, as noted in section 7.2.3 below, where the financial burden of private health insurance has proved prohibitive for many families, resulting in a significant decline in those taking out private health insurance policies.

Certain groups, such as women, the elderly, those in poor health, and rural residents, are at greater financial risk due to their increased out-of-pocket to total income spending ratios.<sup>114</sup>

A 2010 study by Zuvekas and Selden, also availing of US MEPS data, found on average, that families incurred 44% of non—mental health and 37% of out-of-pocket mental health treatment expenditures in a single month. Families with one or more members experiencing mental health problems were more likely to experience periods when they incurred significant out-of-pocket spending burdens. However, it was not the treatment of mental health concerns that was the primary major contributor to high out-of-pocket spending burdens. Instead, the principal contributor to the financial burden was other medical conditions and the fact that families with mental health problems tended to have lower than average incomes.<sup>115</sup>

#### 4.1.2 Disproportionate impact on vulnerable groups

A 2000 study by McAlpine and Mechanic on the utilization of speciality mental health services found that the severely mentally ill tended to be disproportionately African American, unmarried, male, less educated, and have lower family incomes than those with other disorders and those with no measured mental disorders. In a 12-month period almost three-fifths of persons with severe mental illness did not receive specialty mental health care. One in five persons with severe mental illness is uninsured, and Medicare or Medicaid insured 37%. Persons covered by these public programs were over six times more likely to have access to specialty care than those who were uninsured.

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<sup>113</sup> Banthin J S, Cunningham P & Bernard D M (2008) 'Financial burden of health care, 2001-2004'. *Health Aff (Millwood)*. 27(1):188-95

<sup>114</sup> Bennett K J & Dismuke C E (2010) 'Families at financial risk due to high ratio of out-of-pocket health care expenditures to total income'. *J Health Care Poor Underserved*. 21(2):691-703

<sup>115</sup> Zuvekas S H & Selden T M (2010) 'Mental health and family out-of-pocket expenditure burdens'. *Med Care Res Rev*. 67(2):194-212

Involvement in the criminal justice system increased the probability that a person would receive care by a factor of about four, independent of level of need. The average number of outpatient visits for specialty care varied little across the type of disorder and the median number of visits (ten) was equivalent for those with a severe mental illness and those with other disorders. Persons with severe mental illness had a high level of economic and social disadvantage. Barriers to care, including lack of insurance, were substantial and many did not receive specialty care. Public insurance programs were the major points of leverage for improving access, and it was recommended that policy interventions should be targeted to these programs. Problems of adequate care for the severely mentally ill might have been exacerbated by the managed care trend and reductions in intensity of treatment.<sup>116</sup>

Although businesses, federal and state governments, and insurance companies are major funding sources for health care, they are just intermediate sources. Ultimately, individuals and families pay all health care costs through out-of-pocket spending, insurance premiums, or federal, state, and local taxes. Rasell *et al* found the distribution of health expenditures to be very regressive, with low-income families paying twice the share of income paid by high-income families. The distribution of out-of-pocket expenditures, which comprise 24% of total spending, is the most regressive, with low-income families paying 8.5 times the share of income on health care purchases as that paid by high-income families. Spending on premiums is also regressive, and it was calculated that this regressivity would increase if everyone had private insurance. Regressivity was found to be greater amongst the elderly with out-of-pocket expenditures accounting for 41% of all their health care spending. On the other hand, public sector expenditures on health were progressive, as they provided more equitable health care services across the board.<sup>117</sup>

#### 4.1.3 Impact of 'out-of-pocket' medical expenses

Research in New Zealand also demonstrated the regressivity of out-of-pocket payments. However, the regressivity did decline in 1993/94 in response to a government initiative to improve the targeting of government subsidies towards lower income households.<sup>118</sup> Socioeconomic disparities were found to exist in the financial burden of out-of-pocket health care expenditures for families with children. In the case of low-income families, full-year public coverage provided significantly greater protection from excessive financial burden as compared with the option of full-year private coverage.<sup>119</sup>

Out-of-pocket medical expenses were found to have a far greater economic impact upon families with an older head of family, at least one family member in poor health or where some adults in the family did not possess health insurance. Similarly, in families where there was no person working full time for the entire year there was a greater risk of impoverishment.<sup>120</sup>

There is a lack of financial protection for health services for a wide segment of the US population-particularly so for poor families and those with multiple chronic conditions.<sup>121</sup>

<sup>116</sup> McAlpine D D & Mechanic D (2000) 'Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk'. *Health Serv Res.* 35(1 Pt. 2):277-92

<sup>117</sup> Rasell E, Bernstein J. & Tang K (1994) 'The impact of health care financing on family budgets'. *Int J Health Serv.* 24(4):691-714

<sup>118</sup> Hopkins S & Cumming J (2001) 'The impact of changes in private health expenditure on New Zealand households'. *Health Policy.* 58(3):215-29

<sup>119</sup> Galbraith A A, Wong S T, Kim S E & Newacheck P W (2005) 'Out-of-pocket financial burden for low-income families with children: socioeconomic disparities and effects of insurance'. *Health Serv Res.* 40(6 Pt 1):1722-36

<sup>120</sup> O'Hara B (2004) 'Do medical out-of-pocket expenses thrust families into poverty?' *J Health Care Poor Underserved.* 15(1):63-75

<sup>121</sup> Waters H R, Anderson G F & Mays J (2004) 'Measuring financial protection in health in the United States'. *Health Policy.* 69(3):339-49.

Many countries rely heavily on patients' out-of-pocket payments to health service providers to finance their health care systems. This approach can result in people with a health/mental health problem not seeking care or for others, who do access the required treatment, it can result in serious financial strain and even impoverishment. Surveys conducted in eighty-nine countries covering 89% of the world's population revealed that each year 150 million people globally suffer financial ruin as a result of being obliged to pay for health services they have accessed. Although prepayment mechanisms can protect people from financial catastrophe, there is a lack of strong evidence to demonstrate that SHI systems offer either better or worse protection than tax-based systems.<sup>122</sup>

#### 4.1.4 Out-of-pocket expenditure and household income - India

In India, estimates show that out-of-pocket expenditure accounts for around 5% of total household expenditure with a higher proportion of out-of-pocket expenditure registered in more rural areas as well as more affluent states. Out-of-pocket expenditure as a percentage of total household expenditure ranges from approximately 2% in Assam to nearly 7% in Kerala. Drug procurement constituted the lion's share of total out-of-pocket expenditure at approximately 70% of the total. Approximately 32.5 million persons fell below the poverty line in 1999-2000 through out-of-pocket payments, implying that the overall poverty increase after accounting for such expenditure is 3.2% (as against a rise of 2.2% shown in earlier literature). Furthermore, the poverty headcount increase and deepening of poverty is much higher in poorer states and rural areas compared with affluent states and urban areas, except in the case of Maharashtra.<sup>123</sup>

Moreover, having health insurance may not be sufficient to prevent health or mental health care services users from having to expend significant sums on their treatment.<sup>124</sup>

#### 4.1.5 Health related expenditure and household welfare

In a 2010 paper, Bredenkamp *et al* examined the impact of health-related expenditure on household welfare in Albania, Bosnia & Herzegovina, Montenegro, Serbia and Kosovo, all of which have undertaken major health sector reform. In the implementation of this study, they assessed the following:

- 1) the incidence and intensity of 'catastrophic' health care expenditure, and
- 2) the effect of out-of-pocket payments on poverty headcount and poverty gap measures.

The data used in the analysis were drawn from the 2000 to 2005 Living Standards and Measurement Surveys. They found that:

- 1) In both Albania and Kosovo, health expenditures were the result of serious impoverishment for many families
- 2) Transportation expenditure accounted for a large share of total health expenditures, particularly in Albania and Serbia
- 3) There were substantial informal payments in all countries, and they were particularly high in Albania.<sup>125</sup>

<sup>122</sup> Xu K, Evans D B, Carrin G, Aguilar-Rivera A M, Musgrove P & Evans T (2007) 'Protecting households from catastrophic health spending.' *Health Aff (Millwood)*. 26(4):972-83

<sup>123</sup> Garg C C & Karan A K (2009) 'Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India'. *Health Policy Plan*. 24(2):116-28

<sup>124</sup> Shen Y C & McFeeters J (2006) *Ibid*

<sup>125</sup> Bredenkamp C, Mendola M & Gragnolati M (2011) 'Catastrophic and impoverishing effects of health expenditure: new evidence from the Western Balkans'. *Health Policy and Planning*. 26(4):349-356

#### 4.1.6 Impact of low levels of savings

Individuals screening positive for any mental health disorder are less than two-thirds as likely as individuals with no mental health problems to have any savings. The percentage of savers declines with age among those with a probable mental health condition, compared to a rise in savings levels with age amongst other individuals, including those who are chronically physically ill.<sup>126</sup> Low levels of saving among older individuals with mental health problems become particularly problematic when these individuals are in transition into Medicare. With limited household wealth, these individuals are the least likely to be able to afford supplemental insurance that covers medications or afford the out-of-pocket costs for newer psychotropic medications.<sup>127</sup>

#### 4.1.7 Impact on persons with depression

Persons with depression have about the same out-of-pocket expenditures while having 11.8% less total medical expenditures (not a statistically significant difference) compared to non-depressed individuals with at least one chronic disease. High out-of-pocket expenditures are a concern for individuals with chronic diseases. A study by Lurie *et al* revealed that those with depression have comparable out-of-pocket expenses to those with other chronic diseases but, given their lower income levels, this may result in a more substantial financial burden.<sup>128</sup>

#### 4.1.8 Impact of direct health costs in low- and middle-income countries

McIntyre *et al* examined the impact on households of direct costs, such as medical treatment and related financial costs, as well as indirect costs including loss of productive time as a result of illness, together with the subsequent responses of households confronted with such costs. This study highlighted the health care financing strategies that placed considerable emphasis on out-of-pocket payments and that could impoverish households. According to the paper there is mounting evidence of households being pushed into poverty or deeper poverty, if they were already impoverished, as a result of substantial medical expenses. This process of immiseration is further aggravated when households experience a loss of income due to ill-health. Health sector reforms in lower and middle income countries since the late 1980s have particularly focused on promoting user fees for public sector health services and increasing the role of the private for-profit sector in health care provision. This has increasingly placed the burden of paying for health care on individuals experiencing poor health.<sup>129</sup>

### 4.2 Economic costs of mental health

The amount of financial resources allocated by a government to the mental health sector serves as a concrete indicator of its commitment to promoting mental health. It is not possible to apply a straight forward cost-benefit analysis in mental health care though benefit measurement may be important for service planning.<sup>130</sup> One way of demonstrating the importance of such funding and thus encouraging governments to ensure adequate funding of public mental health services is by demonstrating the economic consequences of failing to prevent and tackle mental health problems in an effective manner. Such an approach requires specialised research together with the active and public dissemination of the findings of such studies.<sup>131</sup>

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<sup>126</sup> Gresenz C R & Sturm R (2001) 'New dimensions of economic well-being among people with mental illness: evidence from Healthcare for Communities.' *Health Serv Res.* 35(6):1207-27

<sup>127</sup> Ibid

<sup>128</sup> Lurie I Z, Manheim L M & Dunlop D D (2009) 'Differences in medical care expenditures for adults with depression compared to adults with major chronic conditions'. *J Ment Health Policy Econ.* 12(2):87-95

<sup>129</sup> McIntyre D, Thiede M, Dahlgren G & Whitehead M (2006) 'What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?' *Soc Sci Med.* 62(4):858-65.

<sup>130</sup> Sloan F A (1971) *Public Planning Expenditures on Mental Health Service Delivery*. Rand Corporation: New York

<sup>131</sup> Hu T W (2003) 'Financing Global Mental Health Services and the Role of WHO'. *J Ment Health Policy Econ.* 6:145-147

The economic consequences associated with mental health can become further aggravated during economic downturns, such as Europe and many other countries are currently experiencing. At the general health level, the impact of an economic recession can be seen in the impact on households that have experienced reductions in employment and income through the decrease in good nutritional outcomes and lower usage levels of health care when household members fall ill. As more and more families fall into poverty or at risk of poverty, they have fewer resources to pay for out-of-pocket health expenses and so reduce their consumption of health services. A recent survey by Ireland's leading dental insurer DentalCover, for instance, revealed that since the economic downturn some two thirds of families have been visiting their dentist less frequently, leading to an increased risk of serious dental complications in the future.<sup>132</sup>

During economic recessions, women, children, the poor and informal sector workers are likely to be most at risk of experiencing negative health-related consequences, as there is significant pressure to reduce real per capita government spending on health care given the decline in potential government revenues, the risk of currency devaluations and possible reductions in external aid flows. Low-income countries with weak fiscal positions are likely to be the most vulnerable.<sup>133</sup> Relatively wealthier countries who adopt an austerity programme to reduce public costs to bridge the national fiscal deficit, can also see resources allocated to the health/mental health service decline considerably and a subsequent reduction on the ability of many to access these services.

Given its particular nature, mental illness tends not to be as easily recognisably as physical illness and generally does not have fatal consequences as certain more serious physical maladies. Furthermore, in many countries, the general public may not be aware of or admit that a person has a mental illness due to social or cultural stigma. It should be emphasised that this is not only the case in low-resource countries. As discussed below in Chapter 6, research in Ireland showed that stigma can frequently be a problem in high-resource countries also. This factor helps explain the relative low priority given to the provision of mental illness treatment in many countries.<sup>134</sup>

In a 2003 paper, Shekhar Saxena *et al* revealed the alarming statistic that 32% of 191 countries did not have a specific budget for mental health. Furthermore, among the 89 countries that responded with key financial information, 36% (32 countries) that had the relevant information spent less than 1% of their total health budget on mental health. The majority of these countries were in low-income countries in Africa, South East Asia, and Asia with a total population of over 2 billion. Even in high-income countries, many countries spent less than 1% and most spent under 5% on mental health.<sup>135</sup>

The most common method of financing mental health services is tax-based, though many low-income countries depend on out-of-pocket expenditures, the least desirable method of financing mental health services.<sup>136</sup> Although out-of-pocket-payments cannot target needs as effectively or as equitably as alternative systems, it is widely relied on by governments where they are unwilling or unable to pay for certain public health services.<sup>137</sup> Those already reluctant to seek help for a mental health problem (e.g. because of stigma) might be forced by the high cost of out-of-pocket payments to delay treatment until their needs are acute and the necessary care is even more expensive.<sup>138</sup>

<sup>132</sup> Dental Cover.ie (2012) *Dental Cover.ie Survey Results*. 1/June/2012. <http://www.dentalcover.ie/news/2>

<sup>133</sup> Gottret P, Gupta V, Sparkes S, Tandon A, Moran V & Berman P (2009) 'Protecting pro-poor health services during financial crises: lessons from experience.' *Adv Health Econ Health Serv Res*. 21:23-53.

<sup>134</sup> Teh-wei Hu (2003) Financing Global Mental Health Services and the Role of WHO. *J Ment Health Policy Econ*. 6:145-147

<sup>135</sup> Saxena S, Sharan P & Saraceno B (2003) 'Budget and Financing of Mental Health Services: Baseline Information on 89 Countries from WHO's Project Atlas'. *J Ment Health Policy Econ*. 6(3):135-143.

<sup>136</sup> Saxena S, Sharan P & Saraceno B (2003) *Ibid*

<sup>137</sup> Saxena S, Thornicroft G, Knapp M & Whiteford H (2007) 'Resources for mental health: scarcity, inequity, and inefficiency'. *Lancet*. 370:878-889

<sup>138</sup> *Ibid*

In India, the risk of out-of-pocket payments exceeding 10% of household income was much higher for women with depressive disorders than for those with other index conditions.<sup>139</sup> Given the economic costs of ill health, particularly mental health problems, it is important governments bear in mind that while they may save funds up-front by insisting service users make out-of-pocket payments to access the services they require, this could lead to increased costs in the future either through the service user requiring more intensive care due to their inability to pay for treatment or through lost economic output, as discussed above.

Where the essential neuro-psychiatric drugs are available, there are often steep financial barriers to access. Although low income countries have a GNP per capita of less than one twelfth of high income countries, the mean price of basic drugs is only two to three times higher in the established market economies. In other words, basic drugs are relatively less affordable in low income countries, where 40% of mental healthcare costs are paid for out-of-pocket.<sup>140</sup>

Certain important conclusions can be drawn with respect to the situation for mental health service users in low-resource economies. First, user fees are an important barrier to accessing health services, especially for poor people. They also negatively impact on adherence to long-term expensive treatments, although this can be offset to some extent by potentially positive impacts on quality.

Second, user fees are not the only barrier the poor face. Together with other cost barriers, a number of quality, information and cultural barriers must also be overcome before the poor can access adequate health services.

Third, initial evidence on fee abolition in Uganda suggests this policy has improved access to outpatient services for the poor. For this to be sustainable and effective in reaching the poor, fee removal needs to be part of a broader package of reforms that includes increased budgets to offset lost fee revenue, as was the case in Uganda.

Fourth, implementation matters: if fees are to be abolished, this needs clear communication with a broad stakeholder buy-in, careful monitoring to ensure official fees are not replaced by informal fees, and appropriate management of the alternative financing mechanisms replacing user fees.

Fifth, context is crucial. For instance, immediate fee removal in Cambodia would be inappropriate, given that fees replaced irregular and often high informal fees. In this context, equity funds and eventual expansion of health insurance are perhaps more viable policy options. Conversely, in countries where user fees have had significant adverse effects on access and generated only limited benefits, fee abolition is probably a more attractive policy option. Removing user fees has the potential to improve access to health services, especially for the poor, but may not be appropriate in all contexts.<sup>141</sup>

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<sup>139</sup> Patel V, Chisholm D, Kirkwood B R & Mabey D (2007) 'Prioritizing health problems in women in developing countries: comparing the financial burden of reproductive tract infections, anaemia and depressive disorders in a community survey in India.' *Trop Med Int Health*. 12(1):130–39.

<sup>140</sup> Thornicroft G & Maingay S (2002) 'The global response to mental illness An enormous health burden is increasingly being recognised'. *BMJ*. 325(7365):608–9

<sup>141</sup> James C D *et al* (2006) 'To retain or remove user fees?: reflections on the current debate in low- and middle-income countries'. *Appl Health Econ Health Policy*. 5(3):137–53



Payments are usually progressive in SHI, so that higher earners pay more, but not adjusted for health risk. However, the benefits of SHI are generally restricted to those who contribute. High rates of unemployment and disrupted working patterns for people with serious mental illness mean that many people with common mental disorders cannot access SHI. In many countries such as parts of South America, SHI cover is only available to urban populations while in Mozambique, only civil servants are covered. In some East European countries, the revenue generated by those in employment is insufficient to provide health-care cover for the eligible population, and heavy subsidies are needed from tax revenues.<sup>142</sup>

A March 2009 study from the Business Roundtable, an association of top U.S. CEOs, found U.S. employers and employees received 23% less value in health care spending than most other countries within the G-8.<sup>143</sup> In the U.S., the nationally representative Health Care for Communities (HCC) survey revealed that three-fifths of persons with severe mental illness had not received speciality mental health care. Numerous studies have shown that insurance increases access to mental health care.<sup>144</sup> So-called managed care arrangements, such as those now widely used in the US, can exclude people with chronic and severe mental illness because of the high costs of their treatment or because premiums are unaffordable.<sup>145</sup>

In Brazil, a 2002 Inter-American Development Bank report also found instances of people with private insurance turning to public health services for costly procedures, contributing to the overall scarcity of resources for those relying solely on the public health system.<sup>146</sup> Although Brazil's national health system model, the SUS, is defined constitutionally as providing universal and comprehensive access to health care, Brazil's financing structure reflects the low level of public financing for health — 3.8% of Brazil's GDP — and the importance of the private sector to the entire system. The majority of the private share consists of out-of-pocket spending, resulting in a difference in payments by people with similar incomes or, in other words, horizontal inequity. The analysis of vertical equity, which considers the distribution of health-sector financing among Brazilians at different income levels, showed that, with the exception of private health insurance financing, the burden of financing penalizes the poorest members of society proportionally more than the richest. This is particularly the case for indirect taxes and out-of-pocket spending.<sup>147</sup>

Market mechanisms and consumer involvement have had a big impact on service delivery in mental health systems.<sup>148</sup> Much of this has been driven by needs for cost containment to control national deficits.<sup>149</sup>

### **4.3 Conclusion**

People and families from a low-income background and/or already under financial strain, face a far greater risk of experiencing greater financial constraints in accessing required mental health services if they are required to make out-of-pocket payments. Given their financial status, they are unable to expend as much on their health care as those from a high-income background, even when faced with a severe or pressing health/mental health care need. For these individuals, the presence of health maintenance organizations may assist in reducing their out-of-pocket health care spending.

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<sup>142</sup> Saxena S *et al* (2007) *Ibid*

<sup>143</sup> Johnson, T. (2009) *Ibid*

<sup>144</sup> Saxena S, Sharan P & Saraceno B (2003) *Ibid*

<sup>145</sup> Saxena S *et al* (2007) *Ibid*

<sup>146</sup> Johnson T (2009) *Ibid*

<sup>147</sup> Ugá M A D & Santos I S (2007) *Ibid*

<sup>148</sup> Shera W (1996) 'Market Mechanisms and Consumer Involvement in the Delivery of Mental Health Services: A UK-US Comparison'. *J. Soc. & Soc. Welfare*. 13

<sup>149</sup> Shera W, Aviram U, Healy B & Ramon S (2002) 'Mental health system reform: a multi country comparison'. *Soc Work Health Care*. 35(1-2):547-75

Furthermore, the placing of limits on prescription drug costs would be another way in which access to acute mental health services for low-income patients with chronic mental illnesses could be improved. As noted below, Ireland has a drug payment scheme though this benefit has been reduced with those requiring drugs and eligible under the scheme being obliged to make greater out-of-pocket contributions towards the medications they require. Limits on coverage for the costs of prescription drugs can increase the use of acute mental health services among low-income patients with chronic mental illnesses and increase government costs, even aside from the increases caused in pain and suffering on the part of patients. Finally, continued high out-of-pocket expenses may impede access to mental health treatment, especially for those requiring greater treatment intensity.

## 5 Socio-economic realities of mental health in Ireland

In discussing the funding modalities applicable in Ireland, it is important to first understand the mental health needs of the population. As the WHO advises and as referred to in Section 2.2 above, there is no one funding system for health/mental health that has universal applicability. It is therefore essential that the particular national environment in which the mental health system operates is properly understood in order to estimate the level of potential service needs and thereby arrive at the most appropriate method of financing, taking into account the available resources. Given the importance of socio-economic factors in determining the rates of mental health needs amongst different sectors of the community, this chapter will examine the prevalence of mental health related problems in Ireland, the general public perception of mental health service users and the socio-economic realities of mental health in Ireland.

### 5.1 Prevalence of mental health related problems in Ireland

A quarter of all adult Irish people suffer from mental health related problems during their lifetime.<sup>150</sup> The 2005/2006<sup>151</sup> and 2007<sup>152</sup> HRB National Psychological Wellbeing and Distress Surveys carried out on the adult Irish population, estimated 389,258 Irish adults (12% of their sample) were experiencing significant psychological distress. A substantial one in five people stated they care for or are related to someone with a mental health problem.<sup>153</sup> It has been estimated that 10% of the general population suffers from depression and 1% from schizophrenia.<sup>154</sup> Table 6 below depicts the prevalence of mental health problems in Ireland.<sup>155</sup>

**Table 6: Prevalence of Mental Health Problems in Ireland**

	%		%
Alcoholism	56	Eating disorder (anorexia, bulimia)	6
Depression	55	Anxiety disorder	5
Suicide	45	Self-harm	5
Drug dependence	37	Panic attacks/disorder	4
Stress	20	Personality disorder	4
Nervous breakdown	12	Obsessive compulsive disorder	1
Schizophrenia	12	Phobias (e.g., agoraphobia)	1
Alzheimer's disease	10	Psychosis	1
Manic depression (bipolar disorder)	9	Post traumatic stress disorder	1
Postnatal depression	7		

As noted in Table 6 above, alcoholism, depression and suicide are the most commonly prevalent mental disorders with around 11,000 episodes of individuals who have deliberately self-harmed presenting at Irish hospital A&E departments annually and up to 500 suicide deaths reported.<sup>156</sup> A lifetime history of suicide related thoughts in certain population groups can reach as high as 49%.<sup>157</sup> Figure 4 below shows age standardised mortality rates for suicide in Ireland compared with the rest of the EU from 1980-1999.

<sup>150</sup> Datta A & Frewen J (2010) *The Socio-Economic Realities of Mental Health in Ireland*. TASC: Dublin.  
[http://issuu.com/tascpublishations/docs/socio-economic\\_realities\\_of\\_health\\_in\\_ireland-fina](http://issuu.com/tascpublishations/docs/socio-economic_realities_of_health_in_ireland-fina)

<sup>151</sup> Tedstone D T & Moran R (2006) *HRB national psychological wellbeing and distress survey: Baseline results*. Health Research Board: Dublin

<sup>152</sup> Doherty D T, Moran R, Kartalova-O'Doherty Y & Walsh D (2008) *Psychological distress, mental health problems and use of health services in Ireland*. Health Research Board: Dublin

<sup>153</sup> HSE (2007) *Mental Health in Ireland: Awareness and Attitudes*. HSE: Dublin.  
<http://www.healthpromotion.ie/hp-files/docs/HSP00612.pdf>

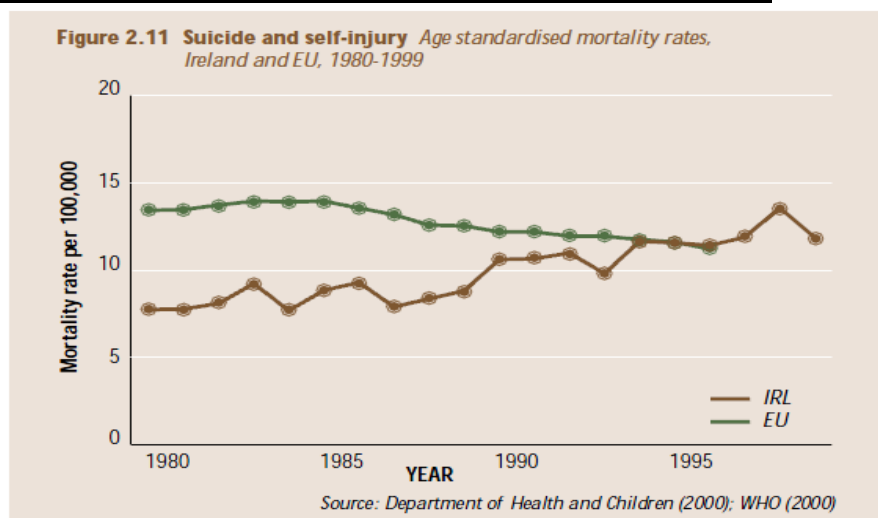
<sup>154</sup> Department of Health and Children (DoHC) (2001) *Quality and Fairness: A Health System for You*. DoHC: Dublin. [http://www.nuigalway.ie/health\\_promotion/documents/strategy.pdf](http://www.nuigalway.ie/health_promotion/documents/strategy.pdf)

<sup>155</sup> HSE (2007) *Ibid*

<sup>156</sup> National Registry of Deliberate Self-Harm in Ireland (2006) *Annual Report*. National Suicide Research Foundation: Ireland

<sup>157</sup> National Suicide Research Foundation and National Suicide Review Group (2004) *The Male Perspective: young men's outlook on life*. Mid-Western Health Board: Ireland

#### Figure 4: Prevalence of Suicide and Self-Harm in Ireland



Approximately 6% of the Irish population surveyed took psychotropic medication in the previous year while as many as 31% who reported mental health problems had used psychotropic medication.<sup>158</sup>

##### 5.1.1 Over 65 mental health problems

The percentage of the population over 65 that suffers from depression ranges from 13-23%, depending on the severity of the condition; 5% suffer from dementia; 1% from schizophrenia; 10% from neuroses; 12-18 per 10,000 from alcohol dependence and 8% from a mental disability.<sup>159</sup> This makes depression the most common mental disorder in the over 65 age group. However, it should be noted that there is an under reporting of alcohol dependence and mental handicap.<sup>160</sup>

##### 5.1.2 Adolescent mental health issues

A 2006 study of prevalence of mental disorders amongst adolescents identified 19.4% as being 'at risk'. Of this group 15.6% met the criteria for a current psychiatric disorder, including 4.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide. Binge drinking was associated with both affective and behaviour disorders.<sup>161</sup>

Table 7 below gives an indications of the respective health behaviour of children aged 16 between Ireland and the 26 other EU countries.

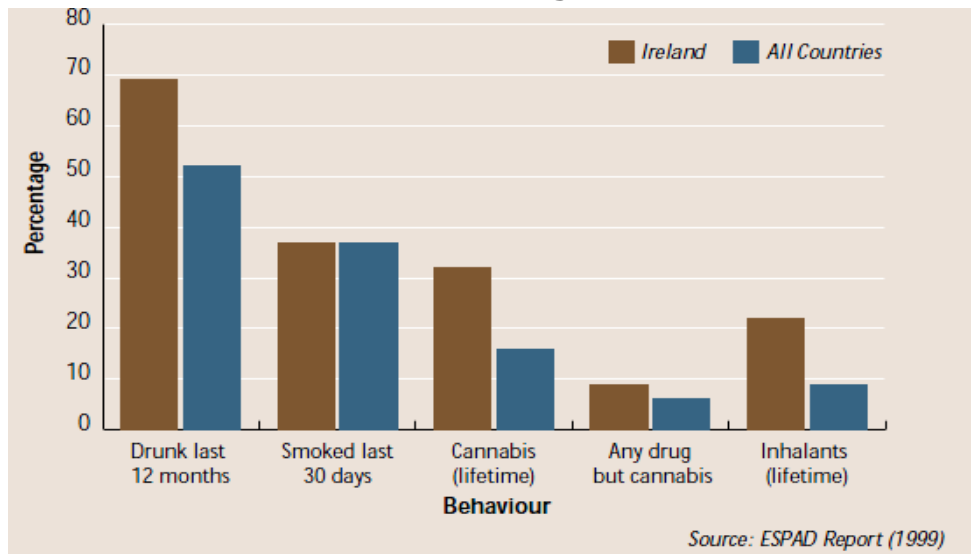
<sup>158</sup> Tedstone Doherty D & Moran R (2006) *Ibid*

<sup>159</sup> National Council for the Elderly (1996) *Proceedings of Conference Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment*. Dublin: Ireland

<sup>160</sup> *Ibid*

<sup>161</sup> Lynch F, Mills C, Daly I, & Fitzpatrick C (2006) 'Challenging times: Prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents'. *Journal of Adolescence*. 29(4):555-573

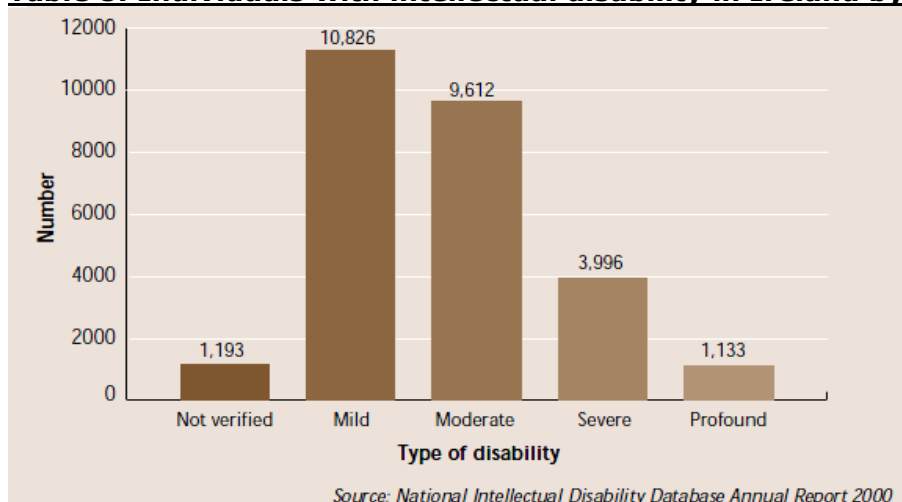
**Table 7: Health behaviour children aged 16 - Ireland & 26 other EU countries<sup>162</sup>**



### 5.1.3 Intellectual disability

There are also a significant number of individuals in Ireland that suffer from intellectual disability, as depicted in Table 8 below.

**Table 8: Individuals with intellectual disability in Ireland by category<sup>163</sup>**



### 5.1.4 Mental Health Commission

In order to monitor the provision of mental health services, the Mental Health Commission (MHC) was established in 2002 under the provisions of the Mental Health Act 2001. The MHC is responsible for developing health information, setting and monitoring standards, promoting and implementing quality assurance programmes nationally, and overseeing Health Technology Assessments (HTA), including the consideration of cost as well as clinical effectiveness and accreditation mechanisms for publicly funded health care services in Ireland. Health care professionals are regulated by the Medical council of Ireland and Health and Social Care councils, under the DoHC.

<sup>162</sup> Department of Health and Children (2001) *Ibid*

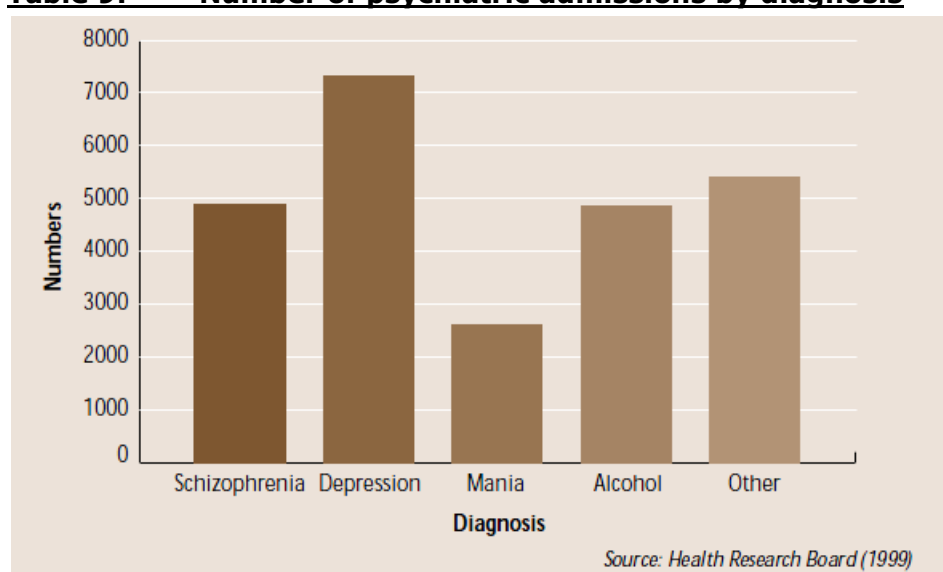
<sup>163</sup> *Ibid*

## 5.2 Mental health service utilisation

In Ireland, the GP tends to be the first port of call for people experiencing a mental health issue. Every year, approximately 10% of the adult population contact their GP to report a psychological problem and on average they will visit their doctor on four occasions with respect to their complaint. This means that over 320,000 people contact their GP in any given year to report a mental health problem, resulting in over 1,280,000 consultations in total.<sup>164</sup>

There has been an increase in admission numbers over a 43-year period (from 15,440 in 1965 to 20,752 in 2008) but overall admission rates have declined (from 535.4 per 100,000 in 1965 to 489.5 per 100,000 in 2008). Admission rates for schizophrenia declined by 59% (from 227.9 per 100,000 in 1971 to 93.1 in 2008), accounting for 19% of all admissions in 2008.<sup>165</sup> Table 9 below shows the number of psychiatric admissions by diagnosis in 1999.

**Table 9: Number of psychiatric admissions by diagnosis**



The rate of first admissions (28%) has not changed significantly over the past 35 years. In 1999, there were 25,062 admissions of people aged 16 years or older (a rate of 930 per 100,000 population), of these, 7,105 were first admissions.<sup>166</sup> Nearly half of all acute beds are used for non-acute purposes resulting in a shortage of acute psychiatric beds. For example, contrary to the intended purpose whereby day hospitals were supposed to be dealing with mental health service users suffering from more acute problems, as many as 94% of mental health patients attending these facilities were only experiencing relatively mild mental illness.<sup>167</sup>

37% of individuals had one or more re-admissions during the period 2001–2005, while 7% were categorised as 'frequent users', having 4 or more re-admissions during that time. Patients diagnosed with alcoholic disorders accounted for one-fifth of patients who were readmitted in spite of the recommendations in place that they should, as far as possible, be treated in community settings.<sup>168</sup>

<sup>164</sup> Tedstone D D & Moran R (2006) *Ibid*

<sup>165</sup> Daly A & Walsh D (2009) *Activities of the Irish Psychiatric Units and Hospitals 2008*. Health Research Board: Dublin; Walsh D and Daly A (2004) *Mental illness in Ireland 1750 - 2002: Reflections on the rise and fall of institutional care*. Health Research Board: Dublin

<sup>166</sup> Department of Health and Children (2001) *Ibid*

<sup>167</sup> Tedstone D D and Moran R (2006) *Ibid*

<sup>168</sup> Daly A, Tedstone D D & Walsh D (2007). *Re-admissions to Irish psychiatric units and hospitals 2001-2005*. Health Research Board: Dublin

In a 2009 study, Daly and Walsh found that the mental health related problems of depressive disorders, schizophrenia and alcoholic disorders had been consistently responsible for approximately two-thirds of total admissions over the preceding years.<sup>169</sup> Catchment areas with home care teams had considerable reductions in re-admissions over a ten-year period, reaching as high as 70% in Cavan/Monaghan against the average decline in re-admission rate of 23% over the same time period for all other services.<sup>170</sup>

In 2006, 1,412 people were resident in 113 high support community residences, an average rate of 46.6 per 100,000 population aged 16 years and over. This figure was well above the 30 per 100,000 recommended high support places.<sup>171</sup> These residences are aimed at continuing care rather than rehabilitation, with the internal environment being less than ideal as a high number of residents shared bedrooms and bathrooms. There was very little difference in symptoms and impairments between residents in low, medium or high support facilities.<sup>172</sup>

Between 1963 and 2006, there was an 83% decline, from 19,801 to 3,389, in the number of persons resident in Irish psychiatric hospitals and units.<sup>173</sup> Although schizophrenia still accounted for the largest proportion of psychiatric inpatients, it declined from 53% of those resident in psychiatric hospitals and units in 1963 to 34% in 2006.<sup>174</sup> The proportion of inpatients resident for a shorter length of stay has increased over the years with a corresponding decrease in those with a length of stay of 5 years or more, from 61% in 1963 to 29% in 2006.<sup>175</sup>

A follow-up study of 450 new long stay patients, identified in the 2006 inpatient census, revealed that two-thirds remained in hospital one year later. 86% of those still in hospital at one year follow-up were resident in 19th century psychiatric hospitals, 2% were in general hospital psychiatric units and 12% were in other psychiatric services.<sup>176</sup> The proportion of patients hospitalised in general hospital psychiatric units has increased from 3% in 1981 to 23% in 2006, while the proportion of patients in older psychiatric hospitals decreased from 90% in 1981 to 52% in 2006.<sup>177</sup>

The rate of non-voluntary admissions has decreased from 130.0/100,000 in 1971 to 37.3/100,000 in 2008. The length of stay for admissions to inpatient services has become shorter over the years with 70% of discharges occurring within one month of admission and 94% occurring within three months of admission.<sup>178</sup>

There were a total of 283,020 discharges with a principal psychiatric diagnosis from psychiatric and general hospitals combined for the period 1997–2006 with the surprisingly high proportion of 17% being from general hospitals. Of discharges from general hospitals giving a principal psychiatric diagnosis, the majority (42.6%) were classified as either alcohol dependence or abuse, while schizophrenia and mania were the almost exclusive preserve of psychiatric units and hospitals.<sup>179</sup>

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<sup>169</sup> Daly A & Walsh D (2009) *Ibid*

<sup>170</sup> Daly A, Walsh D & Tedstone D D (2010) 'Reducing the revolving door phenomena.' *Irish Journal of Psychological Medicine*. 27(1): 27-34

<sup>171</sup> Tedstone D D, Moran R & Bannon F (2007). *High support community residences census 2006*. Health Research Board: Dublin

<sup>172</sup> Tedstone D D, Walsh D & Moran R (2007) *Happy living here... A survey and evaluation of community residential mental health services in Ireland*. Mental Health Commission: Dublin

<sup>173</sup> Daly A & Walsh D (2009) *Ibid*

<sup>174</sup> Tedstone D D & Moran R (2006) *Ibid*

<sup>175</sup> *Ibid*

<sup>176</sup> *Ibid*

<sup>177</sup> *Ibid*

<sup>178</sup> Daly A and Walsh D (2009) *Ibid*

<sup>179</sup> Daly A and Walsh D (2010) 'Psychiatric disorder treated in acute general hospitals: a comparison with psychiatric units and hospitals.' *Irish Journal of Medical Science*. 179(1):85-89

The disturbing trend whereby children have been admitted to adult psychiatric units and hospitals has remained a constant with almost two-thirds (65%) of all admissions aged under 18 in 2008 being referred to adult services. Over a ten-year period more than half of all those aged under 18 years with a psychiatric diagnosis were treated in general hospitals.<sup>180</sup>

Confirming the points made above with respect to the social determinants of health, research has shown that of all the occupation groups in Ireland, the unskilled labour group has consistently had the highest rate of admission over the past thirty years, one that is considerably higher than the rates experienced for employers and managers.<sup>181</sup>

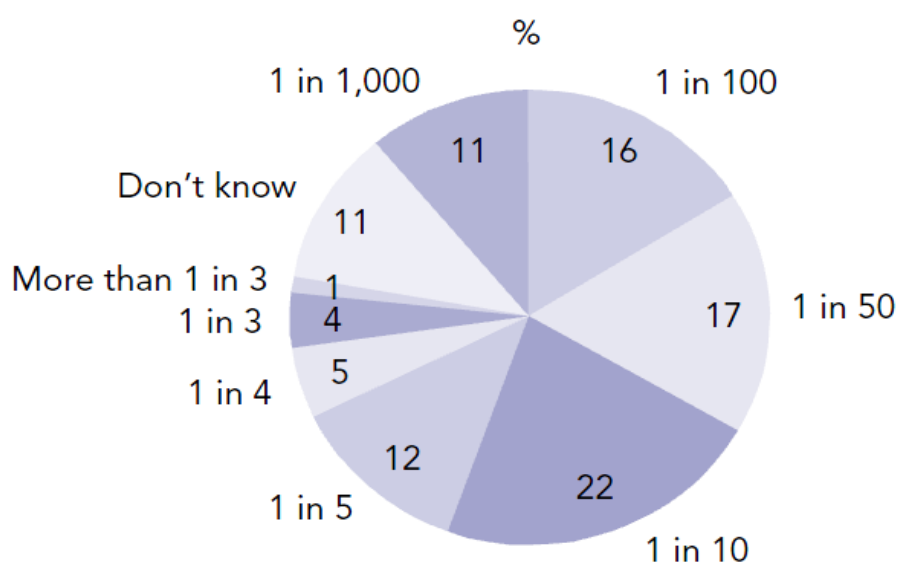
### 5.3 Social perceptions regarding mental health problems in Ireland

#### 5.3.1 Underestimation of mental health problems in Ireland

There is a significant underestimation of mental health problems in Ireland amongst the general population. In a 2005 Health Service Executive (HSE) survey, two thirds of the sample estimated mental illness at a 10% or less prevalence with suicide perceived as the single most important mental health problem. Young males under 35 thought that alcoholism and drug dependency were the most important factors.<sup>182</sup> It should be noted that a 2007 HSE survey concluded that general public awareness of mental health issues derives mainly from media sources. Figure 5 below illustrates the perceived incidence of mental health problems according to this 2007 survey.<sup>183</sup>

**Figure 5: Perceived Incidence of Mental Health Problems**

#### Perceived Incidence of Mental Health Problems



<sup>180</sup> Daly A and Walsh D (2009) *Ibid*; Daly A and Walsh D (2010) *Ibid*

<sup>181</sup> Daly A and Walsh D (2009)

<sup>182</sup> HSE (2007) *Ibid*.

<sup>183</sup> *Ibid*



### 5.3.2 Public attitude towards mental health problems

As discussed above, the public attitude towards mental health is extremely important, as it can influence the relative weight given to tackling mental health issues by the government and other bodies in terms of resource allocation and funding. Surveys conducted in 2003 by Mental Health Ireland,<sup>184</sup> 2007 by HSE<sup>185</sup> and 2010 by See Change<sup>186</sup> found that over 85% of people believe anyone can have a mental illness but that 6 in 10 would not want people to know if they themselves suffered from a mental illness. A similar proportion did not feel that people experiencing a mental illness should perform important jobs. The 2010 See Change study noted a decrease in the overall level of stigma since the 2007 HSE study but also concluded that there was an under reporting of personal experiences of mental illness. At the same time, 2 in 3 believed mentally ill people should have the same rights as everyone else but only 46% agreed to their enjoying the same job rights. Other significant findings included; only 1 in 5 stated they were comfortable working with someone suffering from depression, 48% affirming that they themselves would conceal their diagnosis in the workplace while approximately 2 out of 3 felt people suffering from alcoholism and schizophrenia should not have children.<sup>187</sup>

See Change conducted a follow-up survey in 2012 to gauge the evolution of mental health perceptions in Ireland since the 2010 survey. Major findings included:

1. There was an increase in the number of Irish people who claimed to have experienced a mental health problem, either directly themselves or through others. This was accompanied by an increased awareness and understanding of mental health, mental health problems, stigma and support services.
2. A certain improvement of attitudes was noticeable with respect to the public's understanding of the possibilities of recovery from a mental health problem. However, attitudes to people who were diagnosed with schizophrenia still lag behind. Furthermore, there was an increased willingness to seek professional help for a mental health problem.
3. Unfortunately, these positive developments were negated by the findings that there was a greater reluctance to be open and disclose information about a mental health problem in personal and professional relationships.
4. Finally, the 2012 survey disclosed that there was a more negative perception on the part of peers' reactions to a person's mental health disclosure.<sup>188</sup>

It is clear therefore that considerable work remains to be done to help improve general public awareness and perception of as well as the attitude towards mental health issues. In this respect, it should be noted that the 2007 HSE survey concluded that general public awareness and perception of mental health issues derives mainly from media sources.<sup>189</sup>

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<sup>184</sup> Millward Brown IMS (2003) *Attitudes to Mental Illness*. Mental Health Ireland  
[http://www.sirl.ie/other/repository\\_docs/28.pdf](http://www.sirl.ie/other/repository_docs/28.pdf)

<sup>185</sup> HSE (2007) *Ibid*

<sup>186</sup> Millward Brown IMS (2010) *Public Attitudes Towards Mental Illness: A benchmark study for See Change*. See Change: Dublin

<sup>187</sup> *Ibid*

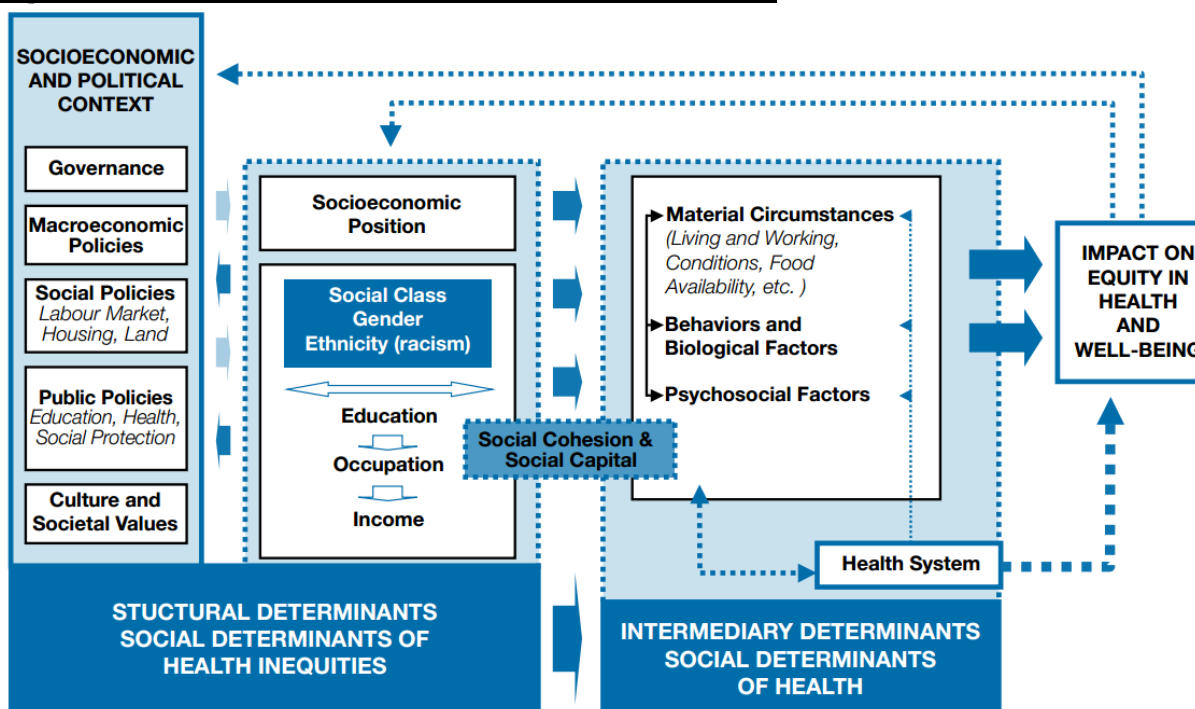
<sup>188</sup> See Change (2012) *2012 Research: Two years into the national stigma-reduction campaign, have attitudes changed?* <http://www.seechange.ie/index.php/stigma-and-discrimination/98-research>

<sup>189</sup> HSE (2007) *Ibid*

#### 5.4 Socio-economic determinants of mental health in Ireland

The social conditions that influence health outcomes, including mental health, are known as the 'social determinants of health'. The World Health Organization (WHO) analysed the social determinants of health and how they can impact on health through the Commission on Social Determinants of Health (CSDH). The CSDH developed a conceptual framework that depicts the relations of social determinants to health as shown in Figure 6 below.

**Figure 6: Relations of Social Determinants to Health**



The social determinants of health concept identifies health as a social phenomenon where health equity is promoted as a guiding criterion and explains causal factors through ideas of social selection/mobility, social causation and life course perspectives.<sup>190</sup>

When one takes into account the fact that research has shown in the case of Ireland that people who are members of the lower socio-demographic groups are 2.5 times more at risk of suffering from arthritis, twice as likely to contract heart disease and three times more likely to experience depression, it is evident that a clear understanding and comprehension of the social determinants of health is essential to improve health equality and reduce the current health inequities that already exist.

Furthermore, it is important that the social determinants of mental health are taken into account, not only as to how they lead to health inequity but also on account of the serious economic and cost implications they have for the economy as a whole. The economic costs of health and mental health inequalities should therefore be taken into consideration when the level of public funding is determined. As Brid O'Connor, CEO of the Mental Health Commission, stated:

<sup>190</sup> Solar O & Irwin A (2010) *A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2*. WHO: Geneva

*Resources are not infinite, so choices must be made between alternative uses of the same resource or service... As the report says, 'economic analysis is therefore a crucial aid to decision making on resource allocation and on priority setting'. While decisions on resource allocation are grounded in values, economics is a central tool in the making of these decisions.*<sup>191</sup>

This section will now examine the impact of certain social determinants on health/mental health.

#### 5.4.1 Education

Education is regarded as a very important route out of poverty and the level of education of any particular individual is a strong indicator of that person's socio-economic status.<sup>192</sup> Early interventions at pre-school age are important to childhood development, breaking the cycle of poverty and educational disadvantage for children, and enabling parents to participate in the labour market. However, these services are relatively underdeveloped in Ireland compared to the rest of Europe.<sup>193</sup> Only 7% of children aged three or under and about half of all four year olds were in pre-school education in 2004.<sup>194</sup> A quarter of the adult Irish population are thought to have low literacy levels.<sup>195</sup>

An example of how the role this disparity in educational attainments can play in determining health outcomes, was clear in the Balanda and White 2003 paper where it was found that people with no formal education qualifications were half as likely as those with third-level education to say they had excellent or very good health.<sup>196</sup> Similarly, of all occupational groups, the unskilled group that had received the least training, had the highest rate of admission for the last thirty years, considerably higher than rates for employers and managers, indicating the clear differences between socio-economic groups.<sup>197</sup>

#### 5.4.2 Employment

Unemployed people were a third less likely than employed people to enjoy a good general mental health score.<sup>198</sup> In Northern Ireland, people who were unemployed were almost twice as likely to show signs of a possible mental health problem compared to those in employment.<sup>199</sup> The 'psychosocial' environment at work also plays an influential role as people who have little opportunity to use their skills and decision-making capacity tend to suffer from worse health than those who have an enriching work environment.<sup>200</sup>

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<sup>191</sup> O'Shea E & Kennelly B (2008) *The Economics of Mental Health Care in Ireland*. Mental Health Commission: Dublin

<sup>192</sup> Farrell C, McAvoy H & Wilde J (2008) *Tackling Health Inequalities: All Ireland Approach To Social Determinants*. Combat Poverty Agency: Dublin

<sup>193</sup> OECD (2004) *Early Childhood Education and Care Policy: Country Note for Ireland*. OECD: Paris. <http://www.oecd.org/ireland/34425332.pdf>

<sup>194</sup> Office for Social Inclusion (2007) *National Action Plan for Social Inclusion 2007-2016*. Government of Ireland: Dublin

<sup>195</sup> Department of Health, Social Services and Public Safety (DHSSPS) (2002) *Investing for Health*. DHSSPS: Belfast

<sup>196</sup> Balanda K & Wilde J (2003) *Inequalities in Perceived Health: A report on the all Ireland social capital and health survey*. Institute of Public Health in Ireland: Dublin/Belfast

<sup>197</sup> Daly A and Walsh D (2009) *Ibid*

<sup>198</sup> Balanda K & Wilde J (2003) *Ibid*

<sup>199</sup> Department of Health, Social Services and Public Safety (2002) *Ibid*

<sup>200</sup> Marmot M, Siegrist J & Theorell T (2006) 'Health and the psychosocial environment at work.' In *Social Determinants of Health* (2<sup>nd</sup> Edition) Marmot M & Wilkinson R (eds). OUP: Oxford

Bullying and harassment can also cause psychological distress at work with just under 8% reporting experience bullying at work. Women were nearly twice as likely to experience bullying as men, with 10.7% of women as compared to 5.8% of men having experienced bullying.<sup>201</sup> There were also relatively more negative perceptions towards people who participated in family friendly programmes together with a greater sense of pressure on employees to work over and above normal hours to get ahead.<sup>202</sup>

Migrant workers, travellers and disabled people in general are a greater risk of experiencing poorer pay and work conditions as well as being unemployed.<sup>203</sup>

#### 5.4.3 Poverty

Poverty is an important risk factor for illness and premature death, affecting health both directly and indirectly as in, *inter alia*, financial strain, poor housing, poorer living environments, poorer diet, limited access to employment, other resources, services and opportunities. Societies with higher levels of income inequality tend to have higher levels of poverty and public investment and lower levels of health and education.<sup>204</sup> A study of homeless people in Ireland found an increased prevalence of depression (46%), cognitive impairment (21.5%), alcoholism (24%), drug taking (38%) as well as hepatitis, diabetes and hypertension compared to the general population.<sup>205</sup>

The rate of hospitalisation for mental illness was over 6 times higher for people in the lower socio-economic groups and the incidence of male suicide amongst the lower socio-economic groups was double that experienced by the higher socio-economic groups.<sup>206</sup> The 2006 Joseph Rowntree Foundation 2006 study of poverty and social exclusion using EU indicators concluded that Ireland ranked in the lower half of the EU league, where first was best, and last worst.<sup>207</sup> Overall 17% of households in Ireland were at risk of poverty, compared to the EU average of 16%, and 6.9% in consistent poverty or combined income-deprivation measure of poverty<sup>208</sup> in 2006.<sup>209</sup>

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<sup>201</sup> O'Connell P, Calvert E & Watson D (2007) *Bullying in the Workplace: Survey Reports 2007*. Department of Enterprise, Trade and Employment: Dublin.

<http://www.djei.ie/publications/employment/2007/esrreportbullying.pdf>

<sup>202</sup> Fine-Davis M, Fagnani J, Giovannini D, Hojgaard L & Clarke H (2004) *Fathers and Mothers: Dilemmas of the Work Life Balance: A comparative study of four European countries*.

<http://www.justice.ie/en/JELR/Fathers&Mothers.pdf/Files/Fathers&Mothers.pdf>

<sup>203</sup> Farrell C, McAvoy H & Wilde J (2008) *Ibid*

<sup>204</sup> Dahlgren G & Whitehead M (2006) *Levelling Up (part 2): A Discussion paper on European Strategies for Tackling Social Inequities in Health*. WHO: Geneva

<sup>205</sup> Condon M (2001) *The Health And Dental Needs Of Homeless People In Dublin*. Northern Area Health Board: Dublin

<sup>206</sup> Battel-Kirk B & Purdy J (2007) *Health Inequalities on the island of Ireland*. Public Health Alliance Ireland for the island of Ireland: Belfast/Dublin

<sup>207</sup> Kenway P, MacInnes T, Kelly A & Palmer G (2006) *Monitoring poverty and social exclusion in Northern Ireland 2006*. Joseph Rowntree Foundation: York, UK

<sup>208</sup> This measure combines relative income poverty with relative deprivation. People whose income falls below the relative income poverty line and who also experience relative deprivation are regarded as living in consistent poverty.

<sup>209</sup> Burke S (2009) *Tackling Poverty: Tackling Health Inequalities*. Combat Poverty Agency: Dublin

**Table 10: Poverty In Ireland In 2006<sup>210</sup>**

	At Risk of Poverty 2006	Consistent Poverty 2006
<b>Total Population</b>	17% (720,770 people)	7% (292,550 people)
<b>Lone Parent Families</b>	40%	33%
<b>Unemployed People</b>	44%	23%
<b>Ill or Disabled People</b>	41%	20%
<b>Children under 14</b>	20%	11%
<b>Older People</b>	14%	2%
<b>Women</b>	17.4%	6.6%
<b>Men</b>	16.6%	6.4%

#### 5.4.4 Income inequality

Ireland has a high degree of income inequality.<sup>211</sup> The EU Survey on Income and Living Conditions (SILC) found that in 2005 those in the top income quintile (the top fifth) had almost five times the income of those in the bottom fifth. The 'economic boom' actually increased the gap between the rich and poor with the Gini coefficient increasing from 31.1% in 2003 to 32.4% in 2005.<sup>212</sup> People living in poverty tended to experience poorer mental health and have a higher dependency on mental health services than people in higher socioeconomic groups.<sup>213</sup>

#### 5.4.5 Housing status

Housing status and the neighbourhood environment generally reflect rather than create social inequalities.<sup>214</sup> Household income levels are strongly linked to health with steep gradients in Ireland.<sup>215</sup> Less well-off people are more likely to live in poor quality built environments, which contributes to poorer health.<sup>216</sup> Homelessness has been associated with extreme poverty and marginalisation and impacts on both physical and mental health.<sup>217</sup>

<sup>210</sup> European Union (2007) *EU Survey on Income and Living Conditions in Ireland 2006*. Central Statistics Office: Dublin. [http://www.cso.ie/en/media/csoie/releasespublications/documents/eusilc/2006/eusilc\\_2006.pdf](http://www.cso.ie/en/media/csoie/releasespublications/documents/eusilc/2006/eusilc_2006.pdf)

<sup>211</sup> Nolan B & Maitre B (2007) 'Economic growth and income inequality: setting the context'. In *Best of Times?: The Social Impact of the Celtic Tiger in Ireland*, Fahy T, Russell H & Whelan C (eds). Institute of Public Administration: Dublin

<sup>212</sup> Ibid

<sup>213</sup> Combat Poverty Agency (2007) *Submission to the OECD Review of the Irish Public Service*. Combat Poverty Agency: Dublin

<sup>214</sup> Farrell C, McAvoy H & Wilde J (2008) *Ibid*

<sup>215</sup> O'Reilly D et al (2006) 'Socio-economic gradients in self reported health in Ireland and Northern Ireland'. *Irish Journal of Medical Science*, 175 (3):43-51

<sup>216</sup> Lavin T, Higgins C, Metcalfe O & Jordan A (2006) *Health Impacts of the Built Environment: A Review*. Institute of Public Health in Ireland: Belfast/Dublin

<sup>217</sup> Farrell C, McAvoy H & Wilde J (2008) *Ibid*

International evidence has identified a clear link between a lack of living space and mental ill-health.<sup>218</sup> People living in cold, damp, energy-inefficient homes and on low incomes are often unable afford to heat their homes adequately and thus suffer from fuel poverty. A review of fuel poverty in Ireland noted that fuel poverty both directly and indirectly has a detrimental effect on health.<sup>219</sup> The direct impact includes the inability to keep warm during cold weather with consequent risks of illness or aggravating current or underlying health conditions. Indirect effects include a financial strain on the household budget, debt, and 'spatial shrink' whereby households occupy fewer rooms during the winter which can, for example, mean limited play or homework space for children in families.<sup>220</sup> These factors can all aggravate mental stress and strain hence potentially contributing to mental health problems.

#### 5.4.6 Urbanisation

There is an increasing dependency on cars, thus compounding concerns about social isolation, reduced opportunities for physical activity, increased obesity, health hazards associated with heavy traffic and environmental pollution, as well as having negative implications with respect to work/life balance.<sup>221</sup>

#### 5.4.7 Access to services

People who are less well-off often find it more difficult to access the services they need for a number of reasons, distance, transport costs, lack of information on available and appropriate services and so forth.

A 2003 Western Health Board study found that 48% of homeless were passed from one service to another, 48% felt that a service did not meet their needs, 46% were unaware of where they should go to access a service, a third believed they had been discriminated against when trying to access a service, 47% had missed a service or not attended one when advised to on account of negative feelings (fear, shyness) or felt that a service would not be helpful due to past experiences and difficulties in relation to time and notification of appointments.<sup>222</sup> A 2007 study found that travellers and immigrants experienced similar difficulties in accessing services.<sup>223</sup>

#### 5.4.8 Social position

Diderichsen's model of "mechanism of health inequality" outlines how social position can account for health inequities. This mechanism emphasises the central role of power which requires action through the political process, engaging both the agencies of the disadvantaged communities and the relevant state authorities. Figure 7 below provides a graphical representation of where action in terms of policy can be taken in order to tackle inequities arising from the disparities in social positions experienced by the general public.<sup>224</sup>

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<sup>218</sup> Ibid

<sup>219</sup> McAvoy H (2007) *All Ireland Policy Paper on Fuel Poverty and Health*. Institute of Public Health in Ireland: Belfast/Dublin

<sup>220</sup> Farrell C, McAvoy H & Wilde J (2008) *Ibid*

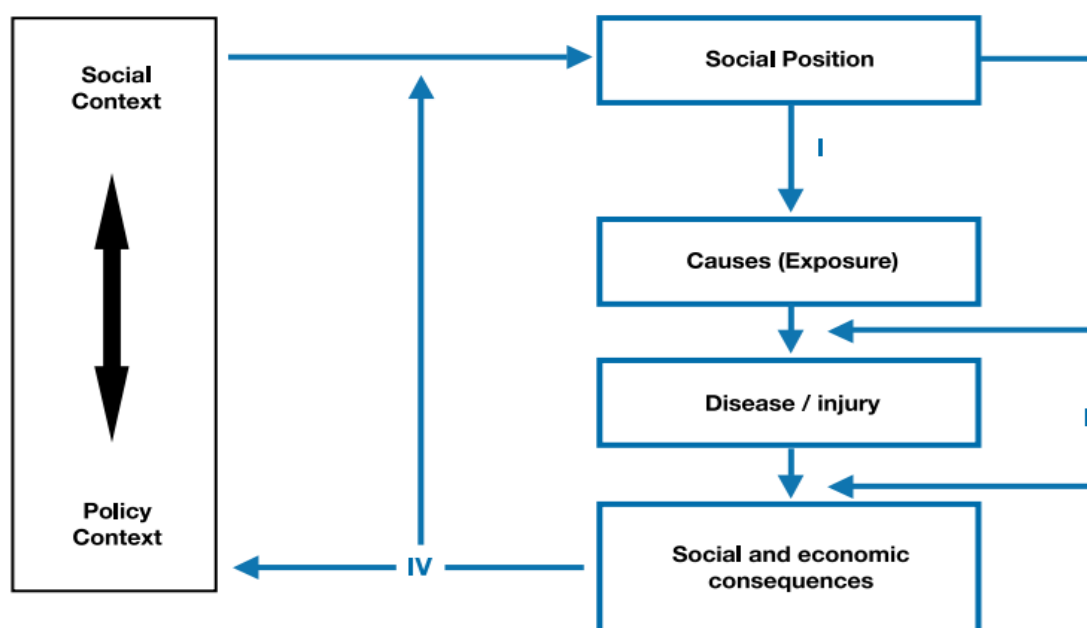
<sup>221</sup> Central Statistics Office (2007) *Census 2006 Volume 12: Travel to Work, School and college*. CSO: Dublin. [http://www.cso.ie/en/media/csoie/census/census2006results/volume12/volume\\_12.pdf](http://www.cso.ie/en/media/csoie/census/census2006results/volume12/volume_12.pdf)

<sup>222</sup> Hourigan S & Evans D S (2004) *A Picture of Health: A Study of the Health Status and Health Promotion of Homeless People in the West Needs*. Western Health Board. [http://www.drugsandalcohol.ie/5853/1/WHB\\_picture\\_of\\_health.pdf](http://www.drugsandalcohol.ie/5853/1/WHB_picture_of_health.pdf)

<sup>223</sup> Battel-Kirk B & Purdy J (2007) *Ibid*

<sup>224</sup> Diderichsen F, Evans T, & Whitehead M (2001) 'The social basis of disparities in health'. In *Challenging inequities in health: From Ethics to Action*. Evans T et al. (eds.) Oxford University Press: Oxford/New York

**Figure 7: Diderichsen's Typology of entry points for policy action on SDH**



### 5.5 Conclusion

Given the recent economic crisis in Ireland, the importance of socio-economic factors in leading to mental health inequalities and taking into account the research that has been carried out with respect to the financial burden created by out-of-pocket expenses, it is clear that there might be a distinct need for increased public spending in the area of health, in general, and mental health in particular, on the part of government to ensure equality of access and reduce health inequalities. However, as we will see below, the opposite is the case as the share of public spending on health has decreased considerably over the past few years since the onset of the recession.

In addition to increased resource allocation to mental health care, together with improved efficiencies in disbursement of these resources, it is important that mental health and therefore, by extension, mental health funding looks at how to intervene to tackle the negative social determinants that lead to health inequalities and higher mental health risks amongst large sectors of the population. This would require intervention not just directly in the public mental health service but across a range of other government departments dealing with social determinants including, employment, education, housing and so forth.

The lack of understanding of mental health issues amongst the general public and the reluctance of a relatively high proportion of the population to empathise with those experiencing mental health problems is of serious concern. This lack of knowledge and understanding of mental health issues needs to be tackled not only because of the damaging effects of stigma on mental health sufferers but also in order to increase awareness of the importance of ensuring adequate mental health funding.



## 6 Irish Mental Health System

This chapter will outline the health care system in Ireland, how it is financed and the primary methods and sources of funding. Furthermore, the allocation of mental health funding and the current status of mental health financing are also examined. Since the onset of the economic recession in Ireland, public spending on healthcare has decreased as a percentage of total spending. Therefore, this chapter will also discuss the issue of out-of-pocket expenditure and private health insurance in the Irish context.

In order to provide relief to individuals that have difficulty meeting health payments and other related costs for a variety of reasons, including negative social determinants such as their economic circumstances, the Irish government operates a variety of schemes to provide assistance. A number of these schemes are detailed and attention is drawn to the fact that they are in the process of being severely curtailed as a result of the on-going recession. These cutbacks will put further pressure on families already under economic pressure with the risk that they might defer mental health treatment as discussed above as well as having a negative impact on the social determinants affecting their health/mental health status.

Moreover, as discussed in section 4.2 above, mental health issues frequently impact on the wider economy and society. Therefore, while immediate savings might be made in cutting back services today, these cutbacks may well result in greater, long-term costs in the future. This issue is examined by looking at the case of out-of-pocket expenses.

### 6.1 The public health care system

The Irish government has overall responsibility for the Irish public health care system, exercised through the Department of Health and Children (DoHC), under the aegis of the Minister of Health and Children (MoHC). Prior to 2005, the public health care system comprised a number of regional Health Boards and the Eastern Regional Health Authority (ERHA). In 2005, these bodies were abolished and replaced by a single organisation, the Health Service Executive (HSE), with the majority of the former health boards' functions and staff relocated within the HSE.

The HSE supervises the delivery of health care services for hospitals, communities and primary care services as well as voluntary hospitals. Public hospitals under the HSE fall under the categories of regional, general, district and specialist types. Regional hospitals are often used to provide teaching services and also provide comprehensive specialist treatments. Services for the mentally ill and those with learning disabilities are provided by special hospitals. The first port of call for those experiencing a mental health problem is generally the General Practices (GP).

### 6.2 Financing the Irish health/mental health system

Although this section will deal with the topic of funding by referring to the Irish health system in general, it applies to the mental health system also, as mental health falls under the umbrella of health and receives its funds through the health system.

#### 6.2.1 Funding breakdown

In Ireland, the health care system is primarily funded by the state through taxation. In 2006, state funding by taxation comprised 78.3% of total health spending.<sup>225</sup> About 10% of health care financing came from co-payments by the service user, a further 10% from other contributors and 2% as receipts from EU regulations.<sup>226</sup> Gross health expenditure in 2007 amounted to almost €14.4 billion or around 25.3% of government spending.<sup>227</sup>

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<sup>225</sup> McDaid D, Wiley M, Maresso A and Mossialos E. (2009) 'Ireland: Health system review.' *Health Systems in Transition*. 11(4):1–268. [http://www.euro.who.int/\\_data/assets/pdf\\_file/0004/85306/E92928.pdf](http://www.euro.who.int/_data/assets/pdf_file/0004/85306/E92928.pdf)

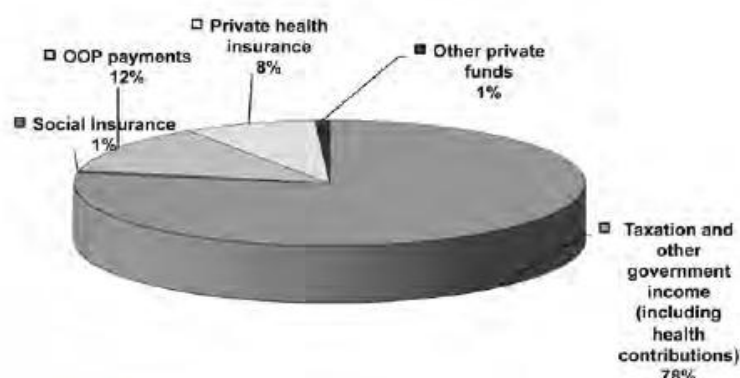
<sup>226</sup> Ibid

<sup>227</sup> Government of Ireland (2008) *2008 Revised Estimates for Public Services*. Government of Ireland: Dublin



Figure 8 shows the breakdown of the sources of funding for the Irish Health System in 2008.

**Figure 8: Sources of funding for the Irish Health System**



Source: OECD, 2008a

Note: OOP: Out-of-pocket (payments)

There has been a decline in general taxation contributions which is attributable to the transition to 2 separate budgets for the DoHC and the HSE. Furthermore, revenue from private and semi-private hospital care and receipts from superannuation were not included as appropriations of the DoHC budget while non-health child welfare services provided by the MoHC were allocated a separate budget. There has also been a rise in contributions from EU member states for the reciprocal use of health services.<sup>228</sup>

Health spending in Ireland experienced a rapid growth in real terms between 2000 and 2009 of 8.4% per annum on average. However, as the economic recession took hold in Ireland, 2010 saw a decrease of 7.6% driven by a sharp reduction in public spending on health as part of government-wide efforts to reduce the budgetary deficit.<sup>229</sup> Despite the cuts in 2010, health spending per capita in Ireland remained above the OECD average, with spending of US\$3,718 in 2010, adjusted for purchasing power parity, compared with an OECD average of US\$3,268.<sup>230</sup>

Health expenditure has continued to be sharply cut back since 2010 and, in 2012, there was a total quantifiable cost reduction target of €750m. This followed total budget cuts of some €1.75bn over the previous two years. Naturally, this has placed serious strain on the Irish health service which has been aggravated by the dramatic reduction in staff levels by over 8,700 since the peak employment levels in 2007.<sup>231</sup>

#### 6.2.2 Increase in health service use out-of-pocket payments

According to OECD statistics, 69.5% of health spending in Ireland was funded by government revenues in 2010, slightly below the OECD average of 72.1%. This was a reduction of 6% from 75.5% in 2007 prior to the economic crisis. This reduction in the public share of health funding can be attributed to a number of measures that were introduced by the government obliging people to engage in more out-of-pocket payments for the services or treatment they receive including, for example, increases in the share of direct payments for prescribed medicines and appliances.<sup>232</sup> As noted in Chapter 5, this approach risks aggravating health/mental health inequities in Ireland.

<sup>228</sup> McDaid D et al (2009) Ibid

<sup>229</sup> OECD (2012) *OECD Health Data 2012: How does Ireland compare?*  
<http://www.oecd.org/ireland/BriefingNoteIRELAND2012.pdf>

<sup>230</sup> Ibid

<sup>231</sup> Health Service Executive (2012) *HSE National Service Plan Executive Summary*. P. 1. HSE: Dublin.  
<http://www.hse.ie/eng/services/Publications/corporate/nspexecutivesummary2012.pdf>

<sup>232</sup> OECD (2012), *ibid*, P. 2

### 6.2.3 Private health insurance

Private health insurance is optional and only a few years ago approximately 50% of the population had taken out private health insurance policies to cover for co-payments charged by state hospitals and for services rendered by private hospitals.<sup>233</sup> However, this figure has decreased substantially over the past few years due to the significant increases in health insurance premiums since the onset of the current economic recession and, at least more recently, the 40% government levy placed on private health insurance.<sup>234</sup> In March 2012, there were 2.14 million private health insurance subscribers, down from 2.3 million at the market's peak at the end of 2008.<sup>235</sup> Between summer 2011 and the end of 2012 it was estimated that 75,000 people would have cancelled their health insurance coverage.<sup>236</sup>

According to the Health Insurance Authority (HIA), by June 2012 this number had reduced by a further 16,000 subscribers, approximately 4%, to 2,123 million.<sup>237</sup> It is therefore currently estimated that some 43% of the population have private health insurance, a decline of 3% from 2010 and 9% from 2005 when 52% of the Irish population had health insurance.<sup>238</sup>

Private Health Insurance was first introduced into Ireland in 1970. However, it was the formation of the European single market in the mid-1990s that required the Irish Government to open up the market for health insurance and allow free competition. This saw competition develop, under the regulations of the 1994 Health Insurance Act. In 2001, the government established the HIA to regulate private health insurance. BUPA Ireland entered the market in 1997 until its operations were taken over by QUINN-Healthcare in 2007. Quinn-Healthcare was placed in administration in 2010 and has recently been renamed Laya Healthcare.<sup>239</sup> A third private health insurance provider, Vivas, entered the market in October 2004 and was subsequently taken over by Hibernian, Ireland's largest insurer and subsidiary of the British Insurance group Aviva. This company changed its trading name to Hibernian Health in July 2008 and then to Aviva in early 2010.<sup>240</sup> In July 2012, a new health insurer Glo Health entered the private health insurance market.<sup>241</sup>

As of September 2006, "the VHI" had over 1.5 million subscribers, giving it a 75% share of the health insurance market, BUPA Ireland (subsequently QUINN-healthcare/Laya Healthcare) had 22.2% of the market with 459,000 members and Vivas 57,000 (2.8%). September 2012 data from the HIA revealed that VHI's domination of the market is in decline as it now held only a 57.3% share of the market in 2011, a decline of almost 10% since 2010 when it held 66.8% of the market. Aviva held a 17.7% share of the market in 2011, up 4% from 2010, when it had a 13.7% share. Despite having been placed in administration in 2010, Quinn Healthcare/Laya Healthcare's share of the market remained relatively constant between 2010 and 2011 at around 21%. There was no data available for Glo Healthcare given its recent entry to the market in July 2012.<sup>242</sup>

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<sup>233</sup> McDaid D, Wiley M, Maresso A & Mossialos E. (2009) *Ibid*

<sup>234</sup> Lynch S (2012) 'Private health care insurance numbers fall another 61,000', *Irish Times*. 7 September 2012. <http://www.irishtimes.com/newspaper/finance/2012/0907/1224323695508.html>

<sup>235</sup> Wall M (2012) 'More expected to abandon private health coverage.' *Irish Times*. 25 May 2012. <http://www.irishtimes.com/newspaper/ireland/2012/0525/1224316664698.html>

<sup>236</sup> *Ibid*

<sup>237</sup> Lynch S, (2012) *ibid*.

<sup>238</sup> MillwardBrown Lansdowne (2012) *Report on the Health Insurance Market*. Health Insurance Authority: Dublin.

[http://www.hia.ie/assets/files/publications/Consumer\\_surveys/HIA\\_Consumer\\_Survey\\_2012\\_Report.pdf](http://www.hia.ie/assets/files/publications/Consumer_surveys/HIA_Consumer_Survey_2012_Report.pdf)

<sup>239</sup> Lynch S (2009) *ibid*.

<sup>240</sup> McDaid D et al, (2009) *ibid*. P. 80

<sup>241</sup> Lynch S (2012) *ibid*.

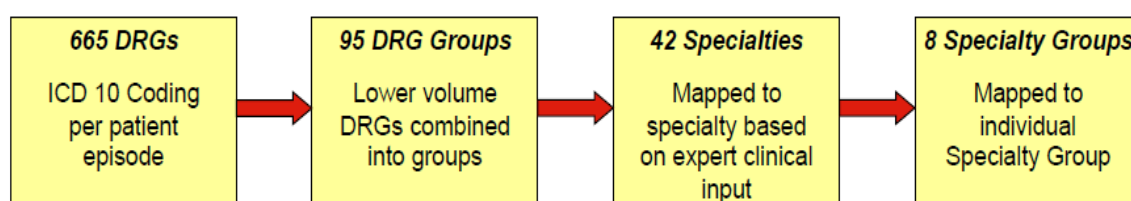
<sup>242</sup> *Ibid*

### 6.3 Allocation of mental health service funding

Gross expenditure on health in 2007 was €14.4 billion or 25.3% of all government spending. Allocation of funds in HSE has been through a case mix model based on Australian Refined Diagnostic Related Group (DRG) version 5.<sup>243</sup>

The hospital in-patient enquiry system (HIPE), records each patient health episode which is then assigned to a DRG using ICD-10.<sup>244</sup> Figure 9 below outlines this process as applied in Ireland.

**Figure 9: DRG to specialty group mapping**<sup>245</sup>



Similar or iso-resource procedures are grouped through the application of a case mix grouper, based on a validated set of patient classes that relate the hospital case mix to resource usage.<sup>246</sup> 665 DRGs are grouped into 42 Specialties and 8 Specialty Groups including mental health.<sup>247</sup>

The “salon model” is used for assigning costs to DRG’s. Ireland uses a system of “Maryland Weights” to quantify the average use of a service by a patient with a particular DRG relative to average use of that service by patients in all other DRG’s. The average Length of Stay (ALOS) for all DRG’s is calculated based on the duration of stay of all patients within each DRG taking outliers into account.<sup>248</sup>

A standard DRG cost for Ireland is calculated from the actual cost of hospitals in the group, each of which is then matched against the standard. Where the DRG cost is higher than standard, money is taken away and where it is lower than the standard, money is received. The pool of money for redeployment is derived from DRGs that redistribute 5% of the cost of day case services and 15% of inpatient services.<sup>249</sup>

In 1992, 50% of the Irish health care budget was being spent on hospital care as compared to 42% by other EU countries.<sup>250</sup> The disbursement of health finance in Ireland has historically been predominantly oriented towards the provision of secondary care. The weight of expenditure devoted to secondary care has decreased to a certain degree in the past few years. Figure 10 which provides a breakdown of health expenditure as it stood in 2001 illustrates this tendency.

<sup>243</sup> Westcott D (2001) *The Irish Healthcare System – a financial perspective*.  
[http://www2.accaglobal.com/pubs/members/publications/sector\\_booklets/healthcare\\_sector/irishhealthcare.pdf](http://www2.accaglobal.com/pubs/members/publications/sector_booklets/healthcare_sector/irishhealthcare.pdf)

<sup>244</sup> Ibid

<sup>245</sup> PA Consulting (2007) *Health Service Executive Acute Hospital Capacity Review: A Preferred Health System in Ireland to 2020 Technical Appendix*.  
[http://www.hse.ie/eng/services/Publications/services/Hospitals/PA\\_Consulting\\_Report\\_-\\_A\\_Prefered\\_Health\\_System.pdf](http://www.hse.ie/eng/services/Publications/services/Hospitals/PA_Consulting_Report_-_A_Prefered_Health_System.pdf)

<sup>246</sup> Westcott D (2001) *Ibid*

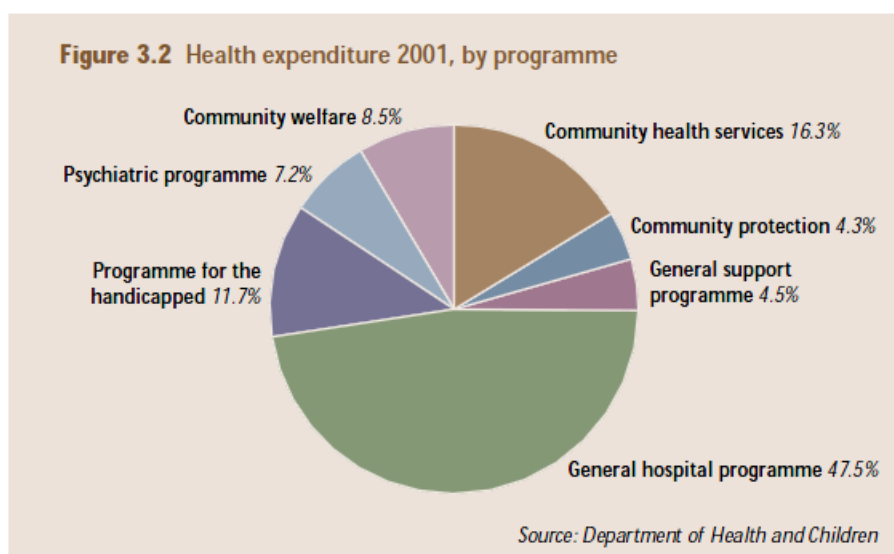
<sup>247</sup> PA Consulting (2007) *Ibid*

<sup>248</sup> Westcott D (2001) *Ibid*

<sup>249</sup> Ibid

<sup>250</sup> Ibid

**Figure 10: Breakdown of Health Expenditure in 2001**



The Eastern Health Shared Services (EHSS) was established in 2000 to process transactions, receipts, payments and payrolls, financial services and provides account reconciliation, assistance in annual budgeting and service planning cycle, budgetary information and reporting and the development of financial reporting system for the Eastern Ireland Regional Health Authority and the three health boards in this region. With the establishment of the Health Service Executive, replacing the previous regional health board, the EHSS has been superseded by the National Shared Services, which will look after a range of services including finance.<sup>251</sup>

#### **6.4 Mental health funding – current status**

Despite the overall reduction in health expenditure, an additional €35m has been allocated to be invested in order to support the further implementation of the required mental health services required to further implementation of *A Vision for Change*, the Irish Mental Health Policy document produced in 2006 and which serves as the blueprint for the reform of our mental health services. These supplementary funds will be directed towards enhancing child, adolescent and adult community teams together with suicide prevention and counselling services. These initiatives will require an additional 400 extra staff. Furthermore, there are plans to open a number of inpatient child and adolescent units in 2012, which have for a long time been a “critical missing service in the spectrum of mental health services”, although the final distribution of the allotted €35m will depend upon further discussion and clarification with the Department of Health (DoH).<sup>252</sup>

However, it has just been revealed that, as has happened in the past, millions of this €35, has once again been diverted to cover cost overruns in other areas of the HSE.<sup>253</sup>

At the same time, mental health services will be subject to budget reductions similar to other health care areas. According to the HSE, these reductions will be achieved through the application of efficiency, procurement and moratorium savings that will result in cost reductions averaging just under 1%, resulting in an overall reduction in the mental health budget from €712 in 2011 to an estimated €707 million in 2012,<sup>254</sup> once the additional investment discussed above has been taken into account.

<sup>251</sup> HSE (2011) *An Introduction to the HSE*.

[http://www.hse.ie/eng/services/Publications/corporate/Intro\\_to\\_HSE.pdf](http://www.hse.ie/eng/services/Publications/corporate/Intro_to_HSE.pdf)

<sup>252</sup> Health Service Executive (2012) *Ibid*. P. 8

<sup>253</sup> O'Brien C (2012) 'Funds for Suicide Prevention Diverted.' *Irish Times*. 29/12/2012.

<http://www.irishtimes.com/newspaper/frontpage/2012/1229/1224328254932.html?via=mr>

<sup>254</sup> HSE (2012) *ibid*

The HSE has noted and raised the issue that the cumulative impact of staff loss since 2009 from the mental health services together with the additional attrition in early 2012, will continue to challenge the organisation in terms of trying to ensure continuity of provision of its services. In effect, these cuts will result in a reduction in inpatient beds in line with the strategic direction of the reform programme and reductions in payments to external agencies who will be challenged to maximise efficiencies.<sup>255</sup>

### **6.5 Health/Mental health service user support programmes**

This section will briefly outline certain of the support schemes in place to provide support to vulnerable groups. Many of the health service user support schemes overlap between those availing of the health service in general and the mental health service in particular.

#### **6.5.1 Access to free or partially free care**

Patients' access to free or partially free care is based on their ability to pay.<sup>256</sup> In this respect, the population has been divided into two broad categories

a) Category 1 – Lowest Income Groups

Category 1 comprises the state's lowest income groups and makes up 30% of the population.

b) Category 2 – Rest of the population.

Category 2 includes all other Irish citizens that do not fit into Category 1<sup>257</sup>

Citizens included in Category 1 benefit from a number of basic entitlements including free GP services, inpatient hospital care, specialist outpatient care, dental and ophthalmic services, the supply of prescription medication as well as maternal and infant welfare services.<sup>258</sup> Specialist mental health services, disability support services and substance abuse services also form part of Category 1 core service entitlements provided free of charge by the government.<sup>259</sup> Since July 2001, all individuals over 70 qualify for a medical card under Category I.<sup>260</sup>

The remainder of the population who come under Category 2 are required to pay for GP services and prescriptions up to a monthly maximum.<sup>261</sup> Secondary care is free for all citizens although certain charges apply for inpatient stays and attendance at A&E.<sup>262</sup>

#### **6.5.2 Means tested GP visit card**

In 2005, a means-tested GP visit card was made available to individuals who were not eligible for a Medical Card but were not economically well off. To qualify for a GP visit card, an individual must meet certain income criteria, which are set at 50 % above the threshold for Category 1. As of December 2007, 75,790 people availed the service.<sup>263</sup>

If an individual believes they are entitled to a GP visit card, they must apply to the HSE for their eligibility to be determined. GP Visit Cards allow individuals and families who qualify to visit their GP for free. However, they are required to pay for prescribed drugs, medicines and/or other health services similar to the rest of the population who do not possess a Medical Card.<sup>264</sup>

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<sup>255</sup> *Ibid.* P. 8

<sup>256</sup> Wescott D (2001) *Ibid*

<sup>257</sup> *Ibid*

<sup>258</sup> *Ibid*

<sup>259</sup> Department of Health and Children (DoHC) (2001) *Ibid*

<sup>260</sup> *Ibid*

<sup>261</sup> Wescott D (2001) *Ibid*

<sup>262</sup> *Ibid*

<sup>263</sup> McDaid D et al (2009) *Ibid*

<sup>264</sup> Health Service Executive (2012) *Your Guide to GP Visit Cards.*

[http://www.hse.ie/eng/services/Find\\_a\\_Service/entitlements/GP\\_Visit\\_Cards/](http://www.hse.ie/eng/services/Find_a_Service/entitlements/GP_Visit_Cards/)

To apply for a GP visit card, the applicant must first apply for a Medical Card. If ineligible for a Medical Card s/he is automatically assessed for the GP visit card. The income guidelines for the GP Visit Card have allowances for items such as rent, mortgages and childcare, thereby allowing many more people to qualify for the GP Visit Card than the Medical Card. When assessed the applicant's means that are taken into account to assess her/his eligibility include property, apart from the applicant's home, investments and savings. Should an applicant's assessed means be above the GP Visit Card income guidelines they might still qualify for the Visit Card should their medical costs cause them undue financial hardship. This situation might arise should the applicant have an on-going medical condition requiring exceptional and regular medical treatment, or visits to the doctor or hospital. Similarly, if the applicant has personal or social issues that cause undue financial hardship to themselves or their family, the Visit Card might be granted to cover the entire family or individual members of the family, depending on the circumstances. Finally, an individual's entitlement to a GP Visit Card is reviewed on a periodic basis, as the economic status of the person who has been awarded a Visit Card might alter.<sup>265</sup>

### 6.5.3 *Treatment Benefit Scheme*

The Treatment Benefit Scheme is operated by the Department of Social Protection. Under this scheme, contributions made by people to the national social insurance fund are paid back to fund the cost of certain health benefits, including dental benefit, hearing aids, contact lenses and Optical Benefit.<sup>266</sup> This scheme is provided to insured workers and retired people having the requisite level of PRSI contribution.<sup>267</sup>

### 6.5.4 *General Medical Services scheme*

Under the 1972 General Medical Services (GMS) Scheme, Category I patients are entitled to a choice of private GPs and pharmacists.<sup>268</sup> General Practitioners (GPs) provide services to medical card holders free of charge. GPs in the General Medical Services (GMS) Scheme enter into contracts with the HSE to provide services. Patients may generally choose their doctor from a panel of doctors who are part of the scheme, provided the doctor is willing to have them as patients. In general, services must be provided by the beneficiary's doctor but there are arrangements for emergencies and for moving out of their area.<sup>269</sup>

### 6.5.5 *Drugs Payment Scheme*

Individuals or families who were registered with their Local Health Office were required to pay up to a maximum of €132 per calendar month in 2012 for approved prescribed drugs and medicines for themselves and/or their families. However, Budget 2013 raised this minimum monthly payment to €144.<sup>270</sup>

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<sup>265</sup> Ibid

<sup>266</sup> Citizens Information (2012) *Treatment Benefit System*.

[http://www.citizensinformation.ie/en/social\\_welfare/social\\_welfare\\_payments/disability\\_and\\_illness/treatment\\_benefit\\_scheme.html](http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/disability_and_illness/treatment_benefit_scheme.html)

<sup>267</sup> McDaid, D. et al (2009) *ibid*.

<sup>268</sup> *Ibid*

<sup>269</sup> Citizens Information (2012) *GP services to medical card holders*.

[http://www.citizensinformation.ie/en/health/gp\\_services/gp\\_services\\_to\\_medical\\_card\\_holders.html](http://www.citizensinformation.ie/en/health/gp_services/gp_services_to_medical_card_holders.html)

<sup>270</sup> Holland K (2012) 'Far bigger 'hit' to those on lower incomes'. *Irish Times*. 7 December 2012.

<http://www.irishtimes.com/newspaper/ireland/2012/1207/1224327611713.html>



The Drugs Payment Scheme provides cover for the person who applied to the scheme together with her/his spouse/partner and children under 18 or, if the children are in full-time education, until they are 23. If there are dependents in the household who suffer from a physical or mental disability/illness and who do not have a Medical Card but are unable to maintain themselves, they may be included in the family expenditure through the Drugs Payment Scheme regardless of the dependent individual's age.<sup>271</sup>

#### 6.5.6 'Fair Deal' Nursing Homes Support scheme

The Nursing Homes Support Scheme, which provides financial support for people requiring long-term nursing home care, replaced the Subvention Scheme which had been in operation since 1993. It requires the person being admitted to the Nursing Home to make a contribution towards the cost of their care with the State funding the balance. This Scheme applies whether the nursing home is public, private or voluntary. Applicants cannot avail of State funding to cover a nursing home place prior to their Fair Deal application receiving being approved. In its 2012 National Service Plan, the HSE estimates the scheme will support 23,611 clients by the close of 2012, an increase of 1,270 on the projected closing position for 2011<sup>272</sup> and has allocated an estimate provision of €1,046.1 million for 2012.<sup>273</sup>

#### 6.5.7 Methadone Treatment Scheme

A 2011 report by the European Monitoring Centre for Drugs and Drug Addiction revealed that Ireland had the higher proportional use of heroin in the EU with drug offences doubling since 2004.<sup>274</sup> In response to the difficulties faced by heroin users in overcoming their addiction, the HSE subsidises a Methadone Treatment Scheme. In 2006 this Scheme provided and dispensed over 217,000 methadone prescriptions.<sup>275</sup> At the end of October 2011, 9,264 people were availing of HSE methadone programmes with a further estimated 10,000 heroin users nationwide not on methadone. Almost 60% of those on a methadone programme have been on it for a year or less, while nearly 1,000 have been on methadone for three years.<sup>276</sup>

The Irish approach to methadone treatment been criticised recently, particularly with release of finding from studies such as the 2009 National Drug Treatment Reporting System showing that only 27% of people on methadone complete their treatment and another third either leaving their methadone programmes or having been refused further sessions. A further 16.6% quit their programmes, having classified themselves as stable.<sup>277</sup>

#### 6.5.8 Illness Benefit

An Illness Benefit payment is available to those who cannot work. The level of allowance depends on previous Pay Related Social Insurance (PRSI) contributions. Supplemental payments are made for spouses, depending on income criteria, and child dependents.<sup>278</sup> The claimant must be under 66 and covered by PRSI. In the government Budget for 2012, it was announced that there would be a tax placed on Illness Benefit from the first day of payment. Previously, Illness Benefit was exempt from tax for the first six weeks of payment. This change was to become effective from 1 January 2012.<sup>279</sup>

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<sup>271</sup> Citizens Information (2012) *Drugs Payment Scheme*.

[http://www.citizensinformation.ie/en/health/entitlement\\_to\\_health\\_services/drugs\\_payment\\_scheme.html](http://www.citizensinformation.ie/en/health/entitlement_to_health_services/drugs_payment_scheme.html)

<sup>272</sup> Health Service Executive (2012), *ibid*, P. 7

<sup>273</sup> *Ibid*, P. 5

<sup>274</sup> O'Connell, B. (2012) 'Is Ireland Failing its Heroin Addicts?' *Irish Times*. 9 January 2012.

<http://www.irishtimes.com/newspaper/features/2012/0109/1224310001769.html>

<sup>275</sup> McDaid, D. et al, *ibid*

<sup>276</sup> O'Connell, B. *Ibid*

<sup>277</sup> *Ibid*

<sup>278</sup> McDaid D et al (2009) *Ibid*

<sup>279</sup> Department of Social Protection (2012) *Illness Benefit*.

<http://www.welfare.ie/EN/Schemes/IllnessDisabilityAndCaring/Illness/IllnessBenefit/Pages/ib.aspx>

#### 6.5.9 Long Term Illness Scheme

There is also a Long Term Illness scheme where individuals who suffer from certain long-term illnesses or disabilities may apply to join the Long Term Illness Scheme. If they are accepted as eligible for this scheme they are provided with a Long Term Illness book. The Long Term Illness books allows the beneficiary access drugs, medicines, and medical and surgical appliances directly related to the treatment of their illness, free of charge. The Long Term Illness scheme does is not means-tested and does not depend on the applicant's income or other environmental circumstances. It is also separate from both the Medical Card Scheme and the GP Visit Card Scheme.<sup>280</sup>

#### 6.5.10 Invalidity Pension

There is also an Invalidity Pension which is not means tested.<sup>281</sup> The Invalidity Pension is disbursed to people who are permanently incapable of work because of illness and it is based on the claimant's social insurance contributions. In addition to satisfying the invalidity requirements, a claimant must have a total of at least 260 weeks social insurance contributions paid since entry into insurance as well as having paid or credited PRSI in 48 weeks of the last complete tax year before the date of claim.<sup>282</sup>

#### 6.5.11 Domiciliary Care Allowance

A Domiciliary Care Allowance is available to those who are responsible as carers for a child with severe disabilities. There is also an Annual Respite Care Grant.<sup>283</sup> The Domiciliary Care Allowance is paid on a monthly basis directly to the care of the child. The child must have a disability that requires them to receive care and attention and/or supervision that is substantially greater than would be required for another child of the same age. This care and attention has to be provided in order to enable the child to cope with the activities of daily living. Furthermore, it must be likely that the child will require this significant level of care and attention for a period of at least 12 months. Initially, the Domiciliary Care Allowance scheme was administered by the HSE before it was transferred to the Department of Social Protection. In the 2012 Budget, it was announced that the age of entitlement for Domiciliary Care Allowance would be increased upwards from 16 years to 18 years of age to compensate for the increase in eligibility age for Disability Allowance to 18.<sup>284</sup> These measures are currently under review.<sup>285</sup>

#### 6.5.12 Household Benefits Package

Citizens over 70 years of age or who are in receipt of an Invalidity Pension or Carer's Allowance are entitled to a household benefits package.<sup>286</sup> In order to be eligible, a potential recipient must be currently living in Ireland and satisfy a number of conditions. Furthermore, only one person per household is allowed to receive the package at any one time. The 2013 Budget has seen further reductions in this package with components such as the telephone and electricity/gas allowance experiencing reductions in value.<sup>287</sup>

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<sup>280</sup> Health Service Executive (2012) *Your Guide to Long Term Illness Scheme*.

[http://www.hse.ie/eng/services/Find\\_a\\_Service/entitlements/Long\\_Term\\_Illness/](http://www.hse.ie/eng/services/Find_a_Service/entitlements/Long_Term_Illness/)

<sup>281</sup> McDaid D et al (2009) *Ibid*

<sup>282</sup> Department of Social Protection (2012) *Invalidity Pension*.

<http://www.welfare.ie/EN/OperationalGuidelines/Pages/invalidity.aspx#part1>

<sup>283</sup> McDaid D et al (2009) *Ibid*

<sup>284</sup> Citizens Information (2012) *Domiciliary Care Allowance*.

[http://www.citizensinformation.ie/en/social\\_welfare/social\\_welfare\\_payments/disability\\_and\\_illness/domiciliary\\_care\\_allowance.html](http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/disability_and_illness/domiciliary_care_allowance.html)

<sup>285</sup> Department of Social Protection (2012) *Minister Burton announces arrangements for review of Domiciliary Care Allowance Scheme*. <http://www.welfare.ie/EN/Press/PressReleases/2012/Pages/pr270612.aspx>

<sup>286</sup> McDaid D, et al (2009) *Ibid*

<sup>287</sup> Citizens Information (2012) *Household Benefits Package*.

[http://www.citizensinformation.ie/en/social\\_welfare/social\\_welfare\\_payments/extra\\_social\\_welfare\\_benefits/household\\_benefits\\_package.html](http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/extra_social_welfare_benefits/household_benefits_package.html)



### 6.5.13 Free Public Transport

Every citizen over 66 years of age who is permanently resident in Ireland is entitled to free public transport, irrespective of their income.<sup>288</sup> Recipients of a Free Travel Pass who are married, in a civil partnership or cohabiting, are entitled in most instances to a Free Travel Pass allowing their partner accompany them free of charge when travelling.

In the case of the recipient of a Free Travel pass being unable to travel alone, it may be possible for them to receive a Companion Free Travel Pass that permits a person over 16 years of age to accompany them.<sup>289</sup>

## 6.6 Conclusion

1/ The reduction in public support for mental health services and increase in private contributions will adversely impact upon those who have fewer resources. While the various support schemes will continue to provide a certain level of support and relief, it should be borne in mind that many of these schemes have been reduced over the past few years and, given the Irish government's commitment to a policy of austerity that is scheduled to continue for at least a couple more years, it is likely that they will be further reduced.

2/ There is a need for ring-fencing of funds that are allocated to the Irish mental health system. This has proved to be an issue in the past as funds have been diverted for other health service purposes. Indeed, as noted above in Section 6.4, it continues to be a serious problem as several million of the €35 million allocated in 2012 to help realise the Irish mental health policy was diverted to cover costs in other areas of the health service. The fact that there is no overall manager with responsibility for the mental health service in the HSE is one of the major issues of concern in this regard.

3/ At the same time that the Irish government is reducing its financing support to the Irish health/mental health system, there are a growing number of Irish people forced to abandon taking out their own health insurance policies as a result of the economic recession allied to the rapid increases in insurance premiums over the past few years. This situation risks placing an increasing number of Irish households at a greater risk of incurring a serious financial burden should one of their members contract a serious health/mental health ailment necessitating costly treatment or services.

4/ Given the decrease in public mental health funding and reduction in overall health resources, there risks being a substantial increase in mental health inequality with respect to access to treatment and services that require out-of-pocket expenses.

5/ The diminution in benefit schemes, as outlined above, will also place further pressure on many Irish families experiencing financial strain. Not only does this reduction risk further restricting the access of many Irish citizens to required mental health services, it will also have a negative impact on their social determinants, thus increasing the possibility that they might suffer from mental health problems.

6/ Given the broad social impact of mental health issues, this paper would argue that the Irish government should at the very least reconsider their approach to mental health funding and introduce 'poverty proofing' to help counterbalance the negative impacts of the economic recession on the more vulnerable sectors of society.

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<sup>288</sup> *Ibid*

<sup>289</sup> Citizens Information (2012) *Free Travel in Ireland*.

[http://www.citizensinformation.ie/en/social\\_welfare/social\\_welfare\\_payments/extra\\_social\\_welfare\\_benefits/free\\_travel.html](http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/extra_social_welfare_benefits/free_travel.html)

7/ Finally, one has to question whether it would be necessary to have such a large number of various support schemes if there was a universal access system for health/mental health in place that ensured Irish citizens they would be able to receive the services they require at low or no cost. Whether this be provided through a social insurance funding system or other funding methodology, such as the private-insurance/managed-competition model in the Netherlands, as discussed in Section 2.4.1, a proper study should be undertaken of Ireland's mental health needs and the resources available given Ireland's current economic status, while also taking into account the personal, social and economic costs of failing to fund a truly effective mental health system.

## 7 Conclusion

At the global level, there would appear to be a general consensus that health/mental health services should be free at the point of delivery in order to ensure universal access to health care. This can be achieved through a variety of modalities including, *inter alia*, government funding through taxation or mandatory social insurance which may be topped with government funding. In the case of resource poor and low income countries, the UN has recommended increased and targeted official development assistance from wealthier countries, the application of better systems of revenue collection, the prioritising of government budgets and additional innovative financing mechanisms to ensure that the required funding for health is available.

At the same time, it is crucial that all funding dedicated to the provision, promotion and delivery of mental health service and prevention schemes is optimally allocated and that wastage is eliminated. In this respect, the WHO has found that as much as 40% of the funding for health gets wasted through inequitable distribution and the inefficient use of resources. It is imperative, therefore, that those with responsibility for the distribution and management of mental health system funding act at all times to ensure the minimal misallocation of funds and the strict utilisation of funds for the purpose to which they were intended. The WHO has recommended a number of procedures to improve performance in these areas and they should be referred to where possible, taking into account local particularities.

As it stands, many countries have indeed benefited from the guidelines and recommendations issued by the WHO as well as other international best practices in the development and implementation of their mental health funding practices. However, at the same time, it is important that one remembers that mental health policy makers do not act in a political or economic vacuum. In fact, it is fair to say that for the greater part it is political, economic, social and cultural concerns that tend to shape many of the funding choices and that these factors are liable to continue to play a significant role in the future. Nor are these external factors limited to any particular category of countries, as they can be seen at play right across the political-economic spectrum ranging from Latin America to Europe, China to the United States, Israel to Africa.

From the analysis above, it is clear that out-of-pocket expenses can create crippling financial burdens for low-income, low-resource families and this fact should be taken into account at all times by those responsible for not only mental health funding but indeed health funding in general. It is hardly surprising that this is a major concern in low-resource countries where there is frequently a heavy reliance on out-of-pocket payments and user fees. However, it is not only in these countries where large sectors of the population can find themselves under financial pressure due to out-of-pocket mental health service payments.

As noted above in the case of Ireland, it is clear that this has become an ever more pressing matter as many families find themselves under severe economic strain due to the recession. Furthermore, it is certain that this financial strain is also being experienced by millions of other families in the European Union, where for example the unemployment rate has risen to its highest ever rate of 11.7%, and other relatively high-resource countries.<sup>290</sup> This has serious implications in terms of financial impoverishment for individuals - and their families - who require costly mental health treatment and who are unable to afford or lack comprehensive health insurance coverage.

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<sup>290</sup> Irish Times (2012) 'Euro Zone Jobless Hits New Heights'. *Irish Times*. 30 November 2012. <http://www.irishtimes.com/newspaper/breaking/2012/1130/breaking15.html>

This situation has particular significance in terms of mental health services due to their strong association with socio-economic determinants, the lack of general public awareness of mental health and the issue of stigma as discussed above. These factors are further aggravated by the comparative levels of 'serious' disability amongst mental health service users and the relatively high requirements for long term care either in hospital settings or in the community that can prove expensive and which households/individuals are unable to finance out-of-pocket without imposing severe financial hardship on their families.

The case study of Ireland is also informative with respect to the fact that despite the fact that a high prevalence of alcohol related problems, depression, suicide and drug abuse in Irish society there appears to be a gross underestimation of mental health problems and lack of awareness of mental health issues amongst the general public. Although it has been estimated that up to 12% of the Irish population suffer from mental health problems such as depression and schizophrenia and that 20% of adolescents run the risk of developing a mental health illness, a large section of the Irish population admit to not having a clear understanding of the issues involved with many remaining unsympathetic to mental health service users. This can have a detrimental impact on the efforts of those campaigning for greater funding of the Irish mental health service as well as disincentivising policy makers with responsibility for allocating mental health funding.

These factors are further exacerbated in the case of Ireland as a result of the major transition health and mental health care are being obliged to undergo due to the economic recession. Although secondary care is in theory free, in spite of costs such as the €100 charge to attend A & E in the absence of a referral letter from a GP, the majority of Irish citizens continue to receive care in the first instance from their GP.

The Irish health care system and, by default, the Irish mental health care system combines public and private elements and structures. Only 33% of the Irish population have access to free public health care while the remainder of the population are obliged to resort to either out-of-pocket payments or to obtain medical insurance, though in many instances the majority of insurance policies require their holders to contribute at least partially towards their health/mental health expenses.

Moreover, as discussed above, the number of health insurance policy holders has undergone a dramatic reduction, a trend that is foreseen to continue into the future. Fewer people are, therefore, covered by health insurance and so are at an increased risk of having to resort to out-of-pocket payments to cover their health/mental health costs. This risk is further increased by the significant health funding cutbacks by the Irish government that has seen expenditure fall to below the EU average.

The combined impact of these factors has placed the Irish healthcare system, which was already experiencing difficulty in coping adequately for its patients, under even greater strain. As more people are forced to rely on out-of-pocket payments that place greater financial burdens on those less well-off, there is a serious risk that health inequalities will rise as more people put off receiving treatment or care for what they might regard as less serious ailments or defer checking out symptoms that might result in serious mental problems in the future. In the case of mental health, these concerns are even higher given the frequent long term nature of mental health treatment and medication usage.

There is therefore a distinct danger that people will not seek mental health care due to its perceived high cost. If this does happen, the possibility is that alcohol related problems, depression and suicide may well increase. As noted above, this has serious potential economic consequences as the rate of 'disability' will increase thus impacting negatively upon overall economic productivity. Additionally, these costs will not only incur in the immediate but could have long term implications.

In short, while budgetary cutbacks in the area of health/mental health might be seen as one way of 'balancing the books' it is important that policy makers are cognisant of the longer term and broader implications of their decisions to reduce mental health expenditure. In effect, saving made through lessening expenditure on mental health might prove illusory with greater economic costs being inflicted on other areas of the economy as a result.

At the same time, there is a need to consider more than just direct public expenditure on mental health services and prevention. As discussed above, social determinants play a decisive role in fostering health inequities between different social sectors and these lead to economic costs on account of the elevated prevalence of mental health illnesses amongst more vulnerable groups. To tackle the increased risk of poor health/mental health experienced by under-resourced members of society, it is essential that attention is paid to tackling other issues that might contribute to poor mental health including, amongst others, poverty and income inequality, poor educational achievements, unemployment, urbanisation and poor housing. Although, such efforts do not fall directly under the rubric of mental health funding, they do have definite cost implications for mental health funding.

A detailed and thorough analysis should therefore be carried out in order to try and gauge the relative impact of negative social determinants and the contribution they make to mental health inequities and related mental health problems so as to see how best they might be reduced. Such an approach would require a change in the overall governmental approach to health/mental health funding together with coordinated and extensive cooperation between different government bodies, the mental health system and various social groups including the private sector.

It is also vital that funding of mental health is protected and ring-fenced to ensure that it is not diverted to other areas in the health services to tackle other needs. This, as discussed above, has been a particular problem in Ireland and in addition to depriving the mental health services of critical funding also introduces uncertainty into the minds of those responsible for implementing mental health policy as they see the resources they require to achieve their operational objectives being removed for other non-related purposes. Apart from the negative effect on staff morale, the diversion of funding in this manner also makes implementation planning extremely difficult as it is impossible to rely on the resources that have been supposedly allocated.

While it is important to emphasise that the reduction in public funding has been dramatic and is increasingly placing strain on many families in Ireland, it is also important to draw attention to the fact that not all resources allocated in the past have been effectively and efficiently distributed and expended. Therefore, although there are clear arguments that the cuts in health/mental health funding need to be reversed in many instances, this does not mean that greater efficiencies cannot be achieved in the Irish mental health system. The Irish mental health service needs, like all health/mental health services, to remain constantly vigilant to ensure that funding received is utilised in an accountable manner for the purpose for which it was originally designated. At the same time, funds should be distributed and spent in an equitable manner in order to ensure, to the greatest extent possible and resources permitting, universal access to mental health services.

There is also a need to ensure that the public health system obtains maximum value for the funds it expends on medicines and that in addition to providing quality products that the pharmaceutical companies do not overcharge. The option of generic medicines needs to be encouraged and if necessary might be given further weight through the appropriate legislation.

Several commentators have argued that the current public-private funding situation in Ireland should be revisited, given the negative impact it has had on those less well-off.<sup>291</sup> Options that might be considered include, for example, a government sponsored funding of the health services through taxation similar to the NHS in the UK, where the vast majority of services are provided free. Alternatively, the Irish government might consider adopting the funding model favoured by many countries in Europe where social health insurance covers all citizens. This system could be accompanied by a pooling of resources, income based payments and government top-ups where required.

Alternatively the Irish government could look at the option of providing funding to help cover more expensive longer term care such as secondary and tertiary health services as well as mental health and introduce mandatory health insurance for all other health care needs. This mandatory health insurance scheme might be based on income related payments in addition to a pooling of resources. If operated effectively it could help to ensure a broader and more equitable level of universal coverage. Although it has been pointed out that such a scheme might risk exposing the system to the risk of leaving itself open to being abused by individuals who might 'over-use' the system, this problem could largely be avoided by placing a cap on the number of times a person might be seen in a fortnight. Should it be decided to establish a social health insurance or mandatory insurance framework, a regulatory body should be established to ensure that the premiums that are established are appropriate to the level of cover provided and that the insurance companies honour their commitments.

Finally, given the importance of mental health not only to the individuals who are experiencing a mental health problem but also their families and indeed the nation at large, it is crucial that the government and health authorities make every effort to develop a mental health system that truly responds to the needs of their country's citizens. A critical element in ensuring that this mental health system will be successful will depend on identifying and implementing the appropriate funding structure, given the country's level of resources, political-economic system and social structure. The failure to do so will result in an ineffective and under-resourced mental health system that is unable to respond properly to the needs of its service users that, in addition to leading to greater individual suffering, will potentially result in greater economic costs in the future.

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<sup>291</sup> Burke S (2010) *Irish Apartheid: Healthcare Inequality in Ireland*. New Island: Dublin; Burke S & Pentony S (2011) *Eliminating Health Inequalities: A Matter of Life and Death*. TASC: Dublin.  
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